Arizona Department of Corrections
Counseling and Treatment Services - Mental Health
Procedural Instruction

Subject: **Assessment and Classification for Mental Health Scores**
Number: **ACL0001**
Effective Date: **July 31, 2007**
Last Revision Date: **New**

All Arizona Department of Correction Inmates will be assessed for mental health needs. Based on this assessment and outcome a mental health score will be assigned. Mental health staff will ensure that mental health score will be based on the corresponding criteria below. Assigned mental health staff will ensure that any changes to a mental health score will be documented in the medical file and entered in the Adult Information Management System.

Mental Health (MH) Score and Corresponding Criteria
Global Assessment Functioning (GAF) Scale

MH-5 Severe – An inmate requiring specialized placement that provides intensive psychological and psychiatric services. Inmate has an immediate need for psychiatric intervention (medication evaluation and monitoring) and mental health programming with increased vigilance from Operations security staff. Inmate will require Operations security supervision in order to program in areas such as education and work.

Subcode S (applies to MH scores of 2-5) – An inmate identified with a history of a suicide attempt(s) warranting preference to shared housing assignment.

MH 5 Severe Need for Services – Criteria - GAF 0-30

1) *Inmate is in persistent danger of severely hurting him/herself or others (e.g., recurrent violence) or is persistently unable to maintain minimal personal hygiene or displays serious suicidal acts with clear expectation of death.*
2) *Inmate displays some danger of hurting self or others (e.g., suicide attempts without clear expectation of death: frequently violent: manic excitement) or occasionally fails to maintain minimal personal hygiene (e.g., smears feces and/or urine) or displays gross impairment in communication (e.g., largely incoherent or mute).*
3) *Inmate displays behavior that is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or inability to function in general population.*

MH-4 Moderate – An inmate requiring frequent contacts with a potential therapeutic benefit from a more structured housing assignment that provides psychiatric services (medication evaluation and monitoring) and mental health services with increased vigilance from Operations security staff. Inmate needs mental health assessment for clearance to work and participate in educational programming.

Subcode S (applies to MH scores of 2-5) – An inmate identified with a history of a suicide attempt(s) warranting preference to shared housing assignment.

MH 4 Moderate Need for Services – Criteria - GAF 31-60

1) *Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure or irrelevant) or major impairment in several areas, such as work or education, peer relations, communication with DOC staff, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work).*
2) *Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent violation of DOC policy, or any serious impairment in socialization within DOC general population inmates.*
3) *Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks or frequent bouts of anxiety)*

MH-3 Mild – An inmate requiring placement in an institution that has access to psychiatric and mental health staff and services. Inmate is able to participate in work, education, and leisure activities with no mental health supervision.

Subcode S (applies to MH scores of 2-5) – An inmate identified with a history of a suicide attempt(s) warranting preference to shared housing assignment.

MH 3 Mild Need for Services – Criteria – GAF 61-80

1) *Some mild symptoms (e.g., depressed mood and vegetative symptoms) or some difficulty with social, work, or education participation, but generally functioning well, has some meaningful interpersonal contacts.*
2) *If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after an incident): no more than slight impairment in daily living skills.*

MH-2 Identified – Inmate does not require placement in an institution that has comprehensive mental health services. Inmate has a history of mental health problems or treatment, but has no current need for services.

Subcode S (applies to MH scores of 2-5) – An inmate identified with a history of a suicide attempt(s) warranting preference to shared housing assignment.

MH 2 Identified History, No need for services - Criteria GAF 81-90

1) *Absent or minimal symptoms (e.g., mild anxiety to changes in housing). Good functioning in all areas, interested and involved in a wide range of activities, socially effective, no more than everyday problems or concerns.*
2) *Inmate has no history of services within 18 months prior to incarceration or needed services due to active illness for a minimum of one year within ADC.*
3) *Inmate never identified with a Serious Mental Illness (SMI).*

MH-1 None – An inmate not requiring placement in an institution that has comprehensive mental health services. The inmate has no known history of mental health problems, treatment, or services.

MH1 No Identified History, No need for services – Criteria GAF 91-100

1) *Average (unimpaired) functioning in a wide range of activities, appropriate in daily living skills, able to resolve conflicts independently with minimal to no intervention. No mental health symptoms.*

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Subject: **Administrative**
Number: **AD0001**
Effective Date: **9/22/05**
Last Revision: **4/10/07**
Title: **Information Sharing Among CTS Staff**

It is the purpose of this procedural instruction to inform Counseling and Treatment Services (CTS) staff that a team approach to clinical services requires the sharing of clinical information among members of the CTS team. Please share information in accordance with the following guidelines.

Based on the determination of the Arizona Department of Corrections (ADC) Key Contact Psychologists, the Counseling and Treatment Services Administrator, the Health Services Administrator, the Mental Health Program Manager, the Sex Offender Treatment Administrator, and the Addiction Treatment Services Administrator, the following is instructed:

1. ADC CTS staff will share information among themselves for the purposes of evaluation and coordination of treatment efforts.

2. ADC CTS staff will be held to the prevailing standards of confidentiality.

3. In the event that a request is made to disclose verbal or written information from a Mental Health, Sex Offender or Addiction Treatment Services contractor, an appropriate authorization to release information shall be obtained from the inmate in question (Form 1104-2P).

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Administrative**
Number: **AD0002**
Effective Date: **2/09/07**
Last Revision: **4/10/07**
Title: **Mental Health Key Contact Medical Record and Service Delivery Review**

1.1 Each Key Contact Psychologist shall review a minimum of ten (10) medical/mental health records each month randomly selected from the mental health caseload at the complex (i.e., Mental Health Needs Scores of 3 or above).

1.1.1 The Key Contact Psychologist shall review the selected records according to the attached guidelines (Mental Health Key Contact Medical File and Service Delivery Review Form).

1.1.2 The Key Contact Psychologist shall forward copies of all Mental Health Key Contact Medical File and Service Delivery Review Forms to the Mental Health Program Manager by the eighth calendar day of each month.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Admininstrative**
Number: **AD0003**
Effective Date: **4/10/07**
Title: **Movement of Mental Health Inmates**
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The Key Contact Psychologist or designee shall document requests for movement of inmates for mental health reasons on the AIMS DT08 10 screen and shall e-mail the request to Central Office Movement.

The AIMS DT08 10 screen comment shall document the following:

Date of request
Person making request
Details of request

Specialized Mental Health Programs:

Movement to and from specialized mental health programs (i.e., Alhambra Behavioral Health Treatment Facility, Men's Treatment Unit, Special Management Treatment Unit, Stepdown, and Women's Treatment Unit) shall be requested by the Key Contact Psychologist or designee at the specialized mental health program.

These requests for movement to and from specialized mental health programs shall also be copied to relevant Offender Operations staff (e.g., Deputy Warden for Operations, Deputy Warden, Major, and Captain) and to the Facility Health Administrators at the sending and receiving complexes.

Non-Corridor Complexes:

Movement from non-corridor to corridor complexes (e.g., for placement on precautionary watch or because of a change in Mental Health score) shall be requested by the Key Psychologist or designee responsible for the non-corridor complex.

These requests for movement from non-corridor to corridor complexes shall also be copied to relevant Offender Operations staff (e.g., Deputy Warden for Operations, Deputy Warden, Major, and Captain) and to the Facility Health Administrators at the non-corridor and corridor complexes.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Administrative**
Number: **AD0004**
Effective Date: **4/10/07**
Title: **Movement to ASPC-Phoenix Security Cells**

During normal business hours, including weekends, the Key Contact Psychologist or designee shall ensure that relevant Offender Operations staff (i.e., Deputy Warden for Operations, Deputy Warden, Major, and Captain) and the Facility Health Administrator are notified via email or telephone of any movement of inmates into security cells in Baker Unit (cells 85, 86, and 97) or Flamenco Unit (Quiet Ward all cells, John Ward cells 244 and 245). This notification shall include the reason for the movement to a security cell (e.g., precautionary suicide or mental health watch).

After normal business hours, the Mental Health Urgent Responder shall contact the Security Shift Commander in the event that an inmate requires placement in a security cell for precautionary suicide or mental health watch. The Shift Commander shall be contacted after nursing or mental health staff are provided instructions for the precautionary watch.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Administrative**
Number: **AD0005**
Effective Date: **10/4/05**
Last Revision: **4/10/07**
Title: **Monthly Mental Health Statistical Report**

The purpose of this procedural instruction is to describe how statistics will be collected and reported on a monthly basis.

1. Each Mental Health staff member shall record and submit to the Quality Assurance Manager Encounter Forms documenting service delivery. These forms shall be mailed in interoffice mail to Central Office on a weekly basis until such time that entry of Encounter Form data is automated.

   A. The Key Contact Psychologist shall retain copies of Encounter Forms for his/her areas of responsibility.

   B. In the event that data not summarized in the Monthly Mental Health Statistical Report are required, these data are potentially retrievable from the Encounter Forms.

2. Each Mental Health staff member conducting individual counseling or therapy will maintain on a monthly basis the CTS Individual Tracking Log.

   A. The Individual Tracking Log is intended to record only individual counseling or therapy conducted by licensed Mental Health staff, not crisis intervention, assessment, cell front visits, precautionary watch checks, psychiatric contacts, etc.

   B. Counseling or therapy is defined as individual encounters with inmates lasting longer than 15 minutes for the purpose of providing individual therapy or counseling. Typically these encounters will occur in an office or treatment room setting. Inmate receiving this type of service will be considered to be on the staff member's individual counseling or therapy caseload.

3. Each Mental Health staff member leading group therapy or structured psycho-educational classes will maintain on a weekly basis the CTS Weekly Group Tracking Log.

A. The Weekly Group Tracking Log is intended to record either group therapy provided by licensed Mental Health staff or structured psycho-educational classes provided by either unlicensed or licensed Mental Health staff.

B. When two or more Mental Health staff co-lead a group, only one staff member will maintain the Weekly Group Tracking Log and be designated as leading the group or class.

4. The Key Contact Psychologist or designee shall maintain the Suicide and Mental Health Watch Monthly Report (1103-22P, 7/30/98).

5. At the end of the month, each Mental Health staff member will compile his/her data on the CTS Monthly Reporting form(s) and submit this form to the Key Contact Psychologist.

A. The Monthly Reporting form is intended to track and summarize the number of inmates receiving individual counseling/therapy and the number of inmates receiving group therapy or psycho-educational classes.

6. The Key Contact Psychologist or designee shall compile all staff CTS Monthly Reporting forms onto an overall Monthly Reporting form(s).

A. One Monthly Reporting form will be prepared for complex general population and, if applicable, a separate Monthly Reporting form will be prepared for each specialized Mental Health program (i.e., ABHTF, including Baker and Flamenco Units; MTU; WTU; SMTU; and Stepdown).

B, The Key Contact Psychologist shall retain copies of all staff members' CTS Monthly Reporting forms.

C. One Monthly Reporting form shall be prepared for each separate rural, non-corridor complex.

Subject: **Administrative**
Number: **AD0005**
Effective Date: **10/4/05**
Revision Date: **3/28/06 1**
Title: **Monthly Mental Health Statistical Report**

7. The Key Contact Psychologist shall also complete the Supplemental Mental Health Monthly Reporting form(s).

   A. One Supplemental Mental Health Monthly Reporting form will be prepared for complex general population and, if applicable, a separate Monthly Reporting form will be prepared for each specialized Mental Health program (i.e., ABHTF, including Baker and Flamenco Units; MTU; WTU; SMTU; and Stepdown).

   B. One Supplemental Mental Health Monthly Reporting form shall be prepared for each separate rural, non-corridor complex.

8. The Key Contact Psychologist shall submit the following to the Mental Health Program Manager no later than the eighth (8th) calendar day of each month:

   A. A Monthly Reporting form for general population.

   B. Monthly Reporting form(s) for specialized Mental Health programs, if applicable.

   C. A Supplemental Mental Health Monthly Reporting form for general population.

   D. Supplemental Mental Health Monthly Reporting form(s) for specialized Mental Health programs.

   E, The Suicide and Mental Health Watch Monthly Report (1103-22P, 7/30/98).

9. The Mental Health Program Manager shall ensure that an overall Mental Health Program report is submitted to the Counseling and Treatment Services Administrator by the fifteenth (15th) calendar day of each month.

10. The Mental Health Program Manager shall retain copies of all overall Mental Health Program reports.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number : **P0001**
Effective Date: **9/22/05**
Last Revision: **4/10/07**
Title: **Citalopram**

Based on the consensus of ADC psychiatric staff meeting on August 15 and September 8, 2005, and the Pharmacy and Therapeutics Committee meeting on September 22, 2005, the following is instructed:

1. All inmates currently receiving escitalopram (Lexapro) will be prescribed generic citalopram at their next psychiatric contact.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0003**
Effective Date: **9/22/05**
Last Revision: **4/10/07**
Title: **Continuation Of Polypharmacy Treatments For Inmates Stabilized At Alhambra Behavioral Health Treatment Facility (ABHTF)**

Based on the consensus of ADC psychiatric staff meeting on August 15 and September 8, 2005, and the Pharmacy and Therapeutics Committee meeting on September 22, 2005, the following is instructed:

1. Mentally disordered inmates who have been psychiatrically stabilized with polypharmacy treatments (i.e., simultaneous typical and atypical antipsychotic medications) while at ABHTF shall have those treatments continued upon return to SMTU if necessary and as long as clinically indicated.

2. The treating psychiatrist/mental health nurse practitioner shall note the inmate's SMTU placement on the prescription.

3. Mentally disordered inmates who have been psychiatrically stabilized with polypharmacy treatments (i.e., simultaneous typical and atypical antipsychotic medications) while at ABHTF shall have those treatments continued upon transfer to other corridor complex units for three (3) months to minimize risk of relapse upon transfer back to general population.

4. After three (3) months, a nonformulary medication request shall be required for mentally disordered inmates who have been psychiatrically stabilized with polypharmacy treatments while at ABHTF and then transferred back to general population units.

5. The treating psychiatrist/mental health nurse practitioner shall note the reason for continuation of polypharmacy treatment on the prescription (e.g., date of return from ABHTF).

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0004**
Effective Date: **9/22/05**
Last Revision: **4/10/07**
Title: **Approval Process for Non-Formulary Psychotropic Medications**

Based on the consensus of the Counseling and Treatment Services Administrator, Health Services Pharmacy staff, and the Mental Health Program Manager on September 13, 2005, and the Pharmacy and Therapeutics Committee meeting on September 22, 2005, the following is instructed:

1. Non-formulary requests (NFRs) for psychotropic medications shall be sent to the Pharmacy.

2. The Mental Health Program Manager shall review and approve or disapprove the NFR in consultation with a psychiatrist and a pharmacist.

3. In the absence of adequate substantiating data, NFRs for psychotropic medications will be denied, with the NFR form being returned to the prescribing psychiatrist/mental health nurse practitioner with a request for more information.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0005**
Effective Date: **11/29/05**
Last Revision: **4/10/07**
Title: **Antipsychotic Medication Protocol**

Based on the consensus of the ADC psychiatric staff and the Pharmacy and Therapeutics Committee meetings of 11/29/05, 6/10/06 and 3/3/07, the following is instructed:

1. All inmates who are prescribed antipsychotic medications shall have adequate assessment and monitoring done to ensure that treatment is necessary and effective, in the inmate's best interest, and the possibility of toxic side effects is minimized.

2. Antipsychotic medications shall be prescribed by psychiatrists or mental health nurse practitioners who take all customary actions to establish that treatment is necessary including taking an adequate psychiatric history and performing an adequate mental status examination, pre-treatment evaluation of involuntary movements (Abnormal Involuntary Movement Scale (AIMS).

3. Psychological testing in consultation with psychology and review of prior ADC and non-ADC medical records and institutional records will occur when necessary to establish the inmate's mental health diagnoses with reasonable certainty.

4. Inquiries as to an inmate's functional status with non-medical correctional staff (such as housing unit, educational, recreation and administrative staff) will occur when necessary to establish an inmate's functional status with reasonable certainty.

5. The prescribing provider shall select the specific antipsychotic medication and determine the dose to be used by considering the individual inmate's diagnosis and history and in compliance with the ADC formulary.

6. To be considered a failed trial, all antipsychotic medication trials shall be of at least four weeks duration at the target dosage unless (defined in item 9), unless limited by unmanageable adverse effects. Trials occurring prior to the inmate's arrival at ADC must be confirmed by outside medical records. Trials which occurred during periods of active alcohol or illicit drug abuse shall not be considered adequate.

7. In some cases (especially involving inmate reports of previous life-threatening adverse reactions) temporary non-formulary approval may be granted for up to 90 days while outside records are obtained. It is the responsibility of the prescribing provider, through an order given to the psychiatric nurse, to notify the Medical Records Department that prior records are needed.

8. Lower doses than those in item 9 below shall be used for inmates who respond well to lower doses or who develop unmanageable adverse effects at higher doses.

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Number: **P0005**
Effective Date: **11/29/05**
Last Revision: **4/10/07**
Title: **Antipsychotic Medication Protocol**

9. Target doses for non-responders without limiting side effects are as follows:

   For conventional antipsychotics:
   - haloperidol 15mg per day
   - fluphenazine 15mg per day
   - trifluoperazine 30mg per day
   - perphenazine 32mg per day
   - chlorpromazine 750mg per day
   - thiothixine 30mg per day

   For atypical antipsychotics:
   - risperidone 6mg per day
   - Ziprasidone 160mg per day
   - Abilify 15mg per day

10. For inmates with neither significant tardive dyskinesia (Abnormal Involuntary Movement Scale score greater than five) nor a history of Neuroleptic Malignant Syndrome, the initial medication shall be a conventional antipsychotic, risperidone or ziprasidone.

11. If risperidone, ziprasidone and one or more conventional antipsychotics are all either ineffective or not tolerated, then Abilify shall be used. The maximum dose of Abilify shall be 15mg per day, higher doses require a non-formulary request..

12. Non-formulary medications shall be requested only after a conventional antipsychotic, risperidone, ziprasidone and Abilify have all been tried.

13. Prescribing providers shall take all reasonable precautions to minimize the occurrence of side effects including:

    a) Use of the lowest necessary dose.

    b) Order body weight, fasting blood sugar and serum lipid levels at the time of initiating antipsychotic medication and repeat assessments of body weight, fasting blood sugar and serum lipid levels after three, six and twelve months of treatment and every year thereafter.
    c) Repeat administration of scales to measure involuntary movements (AIMS) every six months.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0006**
Effective Date: **11/29/05**
Last Revision: **4/10/07**
Title: **Seroquel (Quetiapine) And Wellbutrin (Bupropion)**

Consistent with the psychiatric literature and the experience of the ADC psychiatrists, it is found that Seroquel and Wellbutrin are sought and used as drugs of abuse in the correctional setting. This makes their use in the correctional setting hazardous for the inmates to whom they are prescribed as well as to the inmate population as a whole.

Therefore, following the consensus of the ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on November 29, 2005, the following is instructed:

1. All inmates, excluding those currently at the Alhambra and Perryville Reception Centers, currently prescribed Seroquel or Wellbutrin will be prescribed alternative therapy at the time of their next evaluation by a psychiatrist/mental health nurse practitioner. Both medications will be discontinued within six weeks of that evaluation and alternative therapy, as clinically indicated, will be prescribed.

2. All inmates who arrive at the Alhambra and Perryville Reception Centers taking Seroquel or Wellbutrin may continue on those medications during the time in reception, if clinically indicated, until transfer to a complex where the inmate is to be permanently housed.

   A. Inmates arriving on Wellbutrin IR and XL will be switched to Wellbutrin SR.

3. All inmates arriving at an Arizona State Prison Complex, from the Alhambra and Perryville Reception Centers or as Parole Violators, who are taking Seroquel or Wellbutrin will be prescribed alternative therapy at the time of their next evaluation by a psychiatrist/mental health nurse practitioner. Both medications will be discontinued within six weeks of that evaluation. Alternative therapy, if clinically indicated, will be prescribed.

4. Inmates currently taking Seroquel or Wellbutrin, and with less than three months before their anticipated release from ADC, may continue on Seroquel and Wellbutrin, if clinically indicated.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number : **P0007**
Effective Date: **11/29/05**
Revision Date: **4/10/07**
Title: **Clozaril (Clozapine)**

Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on November 29, 2005 the following is instructed:

The Medical Program Manager and Mental Health Program Manager shall ensure that all staff comply with these procedures.

Clozapine is an atypical antipsychotic agent with efficacy in the management of individuals with schizophrenia or schizoaffective disorder. Clozapine is also utilized for those individuals who have intolerable adverse events with other conventional and atypical antipsychotics. The use of this agent carries a risk of agranulocytosis and has specific monitoring requirements dictated by the Food and Drug Administration (FDA). The guidelines for the use of this medication are as follows:

1. All patients treated with Clozapine will be housed at the Alhambra Behavioral Health Treatment Facility (ABHTF).

2. All patients will be educated regarding the potential adverse effects associated with Clozapine, as well as alternative treatments and informed consent will be obtained.

3. All prescribing physicians and patients will be registered with the Mylan Prescription Access System.

4. The ABHTF Health Services Pharmacy will dispense all of the Clozapine through the Mylan Prescription Access System.

5. Monday through Friday, excluding holidays, the pharmacy will print a list of patients with active orders for Clozapine and will send the list to the Clozapine prescribing psychiatrists and ABHTF medical providers.

6. The plan as set forth in Attachment A will be followed to monitor all complete blood count with differentials (CBC) and absolute neutrophil counts (ANC).

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7. The prescribing psychiatrist shall write the initial Clozapine titration schedule as a 14 or 16 day, or 3, 4, 5 or 6 week schedule.

8. Before dispensing the first dose, the Pharmacy will have received a rechallenge number. This will be done for all individuals who are receiving Clozapine (including both those receiving it for the first time and for those who have received Clozapine in the past).

9. Prior to dispensing the initial dose of Clozapine and all subsequent dispensing of Clozapine, the pharmacy and prescribing psychiatrist will verify that a baseline CBC and ANC were obtained by Lab Corp within 48 hours of the initial dose of Clozapine, and within 7 days for those patients being maintained on a weekly Clozapine monitoring schedule.

10. Clozapine will be dispensed for 7 days from the date of the most recent CBC and ANC if on weekly blood count monitoring, or 14 days if on biweekly monitoring, or 28 days if on monthly monitoring status.

11. If a CBC and ANC are NOT reported within 48 hours of the initiation of Clozapine therapy or within 7 days of weekly monitoring or 14 days of biweekly monitoring or 28 days of monthly monitoring, pharmacy will notify the Clozapine prescribing psychiatrist and psychiatric nurse coordinator and <u>WILL</u> <u>NOT</u> dispense any further Clozapine. The physician must reorder the CBC and ANC before further Clozapine dispensing will occur.

12. The laboratory, upon completion of a CBC and ANC will fax one copy of the blood results to the prescribing psychiatrist and one copy to the ABHTF pharmacy.

13. After review of the CBC and ANC, the Clozapine prescribing physician will either approve or disapprove the dispensing of Clozapine.

14. The pharmacy will complete and fax the CBC and ANC results per reporting Form C to the Mylan Clozapine Prescription Access System.

15. Pharmacy and the prescribing psychiatrist will screen all patient medication profiles for possible Clozapine drug interactions upon the initiation of Clozapine and upon the initiation of any other medication for patients taking Clozapine.

16. Carbamazepine will not be dispensed concurrently with Clozapine.

17. The Medical Program Manager, Mental Health Program Manager and the ABHTF Pharmacy Director will review the outcomes of the Clozapine monitoring programs on an annual basis and the procedural instruction will be reviewed and signed annually by all parties.

INITIATION OF THERAPY: HEMATOLOGICAL VALUES

1. Do not initiate in patients with a history of myeloproliferative disorder or Clozapine-Induced agranulocytosis or granulocytopenia.

2. The frequency of CBC and ANC monitoring is weekly for 6 months. After 6 months of continuous weekly therapy when all CBC results include a WBC greater than 3500/cc and ANC greater than 2000/cc, the prescribing physician can begin monitoring the CBC and ANC every 2 weeks for the following 6 months. After 12 months of continuous Clozapine therapy and all results for WBC are greater than 3500/cc and ANC greater than 2000/cc, the prescribing physician can then begin monitoring the CBC and ANC every 4 weeks.

3. If immature WBC forms are present on the CBC then the WBC and ANC should be repeated.

4. At discontinuation of Clozapine therapy, CBC and ANC's must be drawn weekly for at least 4 weeks from the day of discontinuation.

5. A substantial drop in WBC or ANC is defined by a single drop or cumulative drop within 3 weeks of WBC greater than 3000/cc or drop in ANC greater than 1500/cc . If this occurs a repeat WBC and ANC should

be obtained. If repeated results are WBC between 3000/cc and 3500/cc and ANC greater than 2000/cc, then monitoring should occur twice weekly thereafter. When the WBC is greater than 3500/cc and the ANC is greater than 2000/cc return to previous monitoring frequency.

6. Moderate leukopenia is defined as a WBC between 2000/cc and 3000/cc or ANC between 1000/cc and 1500/cc. If moderate leukopenia occurs then Clozapine therapy should be interrupted. Daily CBC and ANC should be obtained until the WBC is greater than 3000/cc and the ANC is greater than 1500/cc. Twice weekly CBC and ANC should be obtained until the WBC is greater than 3500/cc and ANC is greater than 2000/cc. The prescribing psychiatrist may rechallenge (restart Clozapine) when the WBC is greater than 3500/cc and the ANC is greater than 2000/cc. If rechallenged, monitor the CBC and ANC weekly for 1 year before returning to the usual monitoring schedule of every 2 weeks for 6 months, then every 4 weeks thereafter.

7. Severe leukopenia is defined as a WBC less than 2000/cc and severe granulocytopenia as when ANC is less than 1000/cc. If either of these occur discontinue Clozapine treatment and do not rechallenge patient (do not restart Clozapine). Monitor WBC and ANC until normal for at least 4 weeks from the date of discontinuation as follows:

    Daily CBC and ANC until the WBC is greater than 3000/cc and the ANC is greater than 1500/cc, then twice weekly until the WBC is greater than 3500/cc and the ANC is greater than 2000/cc then weekly for 4 weeks after the WBC is greater than 3500/cc and the ANC is greater than 2000/cc.

8. Agranulocytosis is defined as ANC less than 500/cc. If this occurs discontinue treatment and do not rechallenge patient (do not restart Clozapine). Monitor CBC and ANC until normal for at least 4 weeks from day of discontinuation as per item 7 above.

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9. If Clozapine therapy is interrupted for reasons other than abnormal hematological results, then see Attachment B for what monitoring frequency to resume after interruption of Clozapine therapy.

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Subject: **Psychiatry**
Number: **P0008**
Effective Date: **11/29/05**
Last Revision: **4/10/07**
Title: **Psychiatric Prescription Duration**

Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on November 29, 2005, the following guidelines are presented regarding psychiatric prescription duration:

1) Prescriptions for medication written by psychiatrists and mental health nurse practitioners may be written for a duration of up to 6 months.

2) For inmates on multiple medications, when the provider changes the dosage of one medicine the new expiration date should match the expiration date of the other previously written medications. The other medications which are not being changed do not need to be rewritten until approaching their expiration date.

3) Prescriptions for release medication written by psychiatrists and mental health nurse practitioners may be written for a duration of up to 30 days.

4) Controlled substances (benzodiazepines, psychostimulants) are not covered by this instruction.

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Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0009**
Effective Date: **11/29/05**
Last Revision: **4/10/07**
Title: **Interim Follow-up by Psychiatric Nurses (PN IIs)**

Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on November 29, 2005, the following guidelines are presented regarding interim follow-up by psychiatric nurses (PN II):

1. The psychiatrist/mental health nurse practitioner may order a formal follow up of inmates by the PN II.

2. The PN II will assess the inmate within the time frame designated in the order written by the psychiatrist/mental health nurse practitioner. The PN II may also see inmates without a psychiatrist/mental health nurse practitioner order as clinically indicated.

3. Assessment shall include:
   a) current symptoms
   b) response to medications
   c) presence or absence of side effects
   d) safety issues (danger to self or others, ability to function in current environment).

4. If an adjustment in medication may be indicated, either by poor response to treatment or by the presence of adverse effects, the PN II will staff the inmate's case with the treating psychiatrist/mental health nurse practitioner.

5. If the treating psychiatrist/mental health nurse practitioner is not available and the matter is urgent, the PN II will staff the inmate's case with another available psychiatrist/mental health nurse practitioner or the Urgent Response psychiatrist/mental health nurse practitioner.

6. If as a result of the assessment the PN II determines that the inmate requires immediate placement on Mental Health Watch or Suicide Watch for safety reasons, the PN II will initiate the Watch.

7. The PN II will document the inmate contact and any staffing with the psychiatrist/mental health nurse practitioner in the mental health progress notes of the inmate medical record.

Subject: Psychiatry
Number: P0009
Effective Date: 11/29/05
Last Revision: 4/10/07
Title: Interim Follow-up by Psychiatric Nurses (PN IIs)
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8. If the inmate is stable and requires no change in medications, the inmate will follow up with the psychiatrist/mental health nurse practitioner as previously ordered. The PN II may provide additional interim follow with the inmate prior to the inmate's next contact with the psychiatrist/mental health nurse practitioner.

9. If clinically indicated, the PN II may also schedule the inmate to see the psychiatrist/mental health nurse practitioner earlier than previously ordered. Staffing with the psychiatrist/mental health nurse practitioner is not necessary for the PN II to schedule an earlier follow up appointment with the psychiatrist.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0010**
Effective Date: **12/19/05**
Revised: **4/10/07**
Title: **Depot Conventional Antipsychotic Medication Use**

Based on the consensus of ADC Psychiatric Staff, and the Pharmacy and Therapeutics Committee meeting on 7 June 2006, the following guidelines are presented for the use of haloperidol decanoate and fluphenazine decanoate:

1. Haloperidol decanoate and fluphenazine decanoate shall be prescribed in consideration of and in compliance with the medication package inserts.

2. Haloperidol decanoate shall only be used in inmates who have recently (within the past 30 days) demonstrated tolerance to haloperidol (oral liquid and tablets or IM injections).

3. Fluphenazine decanoate shall only be used in inmates who have recently (within the past 30 days) demonstrated tolerance to fluphenazine hydrochloride.

4. The initial target dose of haloperidol decanoate shall be based on the tolerated daily dose of oral or short acting injectable haloperidol.

5. The initial dose of haloperidol decanoate given every four weeks shall be up to ten to fifteen times the daily dose of oral haloperidol.

6. If the inmate was receiving short acting injectable haloperidol the dose of haloperidol decanoate given every four weeks shall be up to twenty to thirty times the daily dose of short acting injectable haloperidol.

7. The initial target dose of fluphenazine decanoate shall be based on the tolerated daily dose of fluphenazine hydrochloride.

8. Twenty milligrams of oral fluphenazine hydrochloride daily shall be considered equivalent to one milliliter (25mg) of fluphenazine decanoate injected every two weeks.

9. Ten milligrams of intramuscular fluphenazine hydrochloride daily shall be considered equivalent to one milliliter (25mg) of fluphenazine decanoate injected every two weeks.

10. Increases in the dose of depot medication shall only occur after the inmate has demonstrated an ability to tolerate an increased dose of short acting medication.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0011**
Effective Date: **12/21/05**
Last Revision: **4/10/07**
Title: **Use of Multiple Concurrent Antipsychotic Medications**

Based on the consensus of ADC Psychiatric Staff, and the Pharmacy and Therapeutics Committee meeting on 7 June 2006, the following guidelines are presented for the use of multiple concurrent antipsychotic medications:

1. Use of multiple antipsychotic medications concurrently in an inmate shall only occur when no single formulary antipsychotic medication yields an adequate therapeutic response.

2. Initiating multiple antipsychotic medications concurrently in an inmate shall require approval as a non-formulary request consistent with the process described in Mental Health Procedural Instruction P0004.

3. Continuation of approved antipsychotic polypharmacy shall be consistent with Mental Health Procedural Instruction P003.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0012**
Effective Date: **6/7/06**
Last Revision: **4/10/07**
Title: **Lithium, Valproic Acid and Carbamazepine**

Based on the consensus of ADC Psychiatric Staff, and the Pharmacy and Therapeutics Committee meeting on 7 June 2006, the following guidelines are presented for the use of lithium, valproic acid and carbamazepine:

1) Serum drug levels should be drawn 10-14 hours after the ingestion of medication.

2) The prescribing Psychiatrist or Mental Health Nurse Practitioner (P/MHNP) shall order serum drug levels to be done one to two weeks after starting treatment and one to two weeks after every dose increase.

3) When doses are stable, serum drug levels should be repeated after three and six months of treatment, and then every six months thereafter. Serum drug levels may be ordered more frequently when clinically indicated.

4) When ordering lithium levels, the P/MHNP shall also order an automated chemistry profile (ACP).

5) When ordering valproic acid and carbamazepine levels, the P/MHNP shall also order an ACP and complete blood count with differential (CBC).

6) The P/MHNP shall order a baseline thyroid profile including a T7 (free thyroxine index) and TSH (thryorid stimulating hormone) when initiating treatment with lithium. The P/MHNP shall recheck the TSH annually as long as the inmate is taking lithium.

7) For inmates starting lithium, the P/MHNP shall order a baseline EKG if the inmate has pre-existing cardiac disease or is age 45 or older.

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Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0013**
Effective Date: **6/7/06**
Last Revision: **4/10/07**
Title: **Lamictal (Lamotrigine)**

Based on the consensus of ADC Psychiatric Staff, and the Pharmacy and Therapeutics Committee meetings on 7 June 2006 and 3 March 2007 the following guidelines are presented for the use of Lamotrigine:

1) Lamotrigine will be prescribed to inmates whose Bipolar depressive symptoms are severe or which resulted in suicide attempts or hospitalization.

2) Lamotrigine will be presribed to inmates with Bipolar depression who have intolerable adverse effects or fail to respond to Lithium, Carbamazepine, Valproic Acid and Antidepressants.

3) Inmates should be started on 25mg at night. There should be no dose increase for the first two weeks. Thereafter, the dose should be increased no more rapidly than by an additional 25mg per day every two weeks.

4) The maximum dose should not exceed 250mg each day.

5) Lamotrigine should be immediately discontinued if the patient develops a drug-related rash.

6) Patients with a history of rash due to Lamotrigine should not be prescribed Lamotrigine.

7) Lamotrigine will only be used at ASPC-PHX. The informed consent form shall contain the wording, "I realize that Lamotrigine is only available at ASPC-PHX and I agree to voluntarily stay at ASPC-PHX as long as I am taking Lamotrigine."

8) Inmates prescribed Lamotrigine will be put on a medical hold which keeps them at ASPC-PHX. The psychiatrist or mental health nurse practitioner ordering Lamotrigine shall notify the Psychologist-III to enter a Medical Hold on the AIMS DT08 97 screen.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0014**
Effective Date: **6/7/06**
Last Revision: **4/10/07**
Title: **Continuation of Psychotropic Medications for Arriving Inmates**

Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on 7 June 2006 the following guidelines are presented for the continuation of psychotropic medications for inmates arriving at the Arizona Department of Corrections (including inmates arriving from private correctional facilities):

For inmates who are not seen by the Psychiatrist or Mental Health Nurse Practitioner (P/MHNP):

1. Medications can be continued on inmates who are not seen provided that the Psychiatric Nurse II (PN II) verifies that the inmate is currently taking the medications through one of the following: a) receipt of a continuity of care form from the referring facility, or b) documentation from a pharmacy, or c) current, properly labeled prescription bottles, or d) verification with outside medical records.

2. The prescribing P/MHNP shall mark an asterisk in the upper left corner of the prescription to indicate that the inmate was not seen and that the PN II has properly verified that the inmate is currently taking the medications ordered.

3. All medications, including those which are non-formulary (excluding controlled substances), can be continued for 28 days without a non-formulary request.

4. The prescribing provider shall order no more than the maximum dosage recommended by the FDA for any medication regardless of the amount the inmate was formerly receiving. Reducing the dose in this manner will not require a non-formulary request.

5. The PN II shall attach a copy of the means of verification to the prescription sent to the ADC pharmacy.

For inmates who are seen by the P/MHNP:

6. Non-formulary medications can be continued on inmates who are seen, without a non-formulary request, provided that the PN II has verified that the inmate is currently taking the medications through one of the following: a) receipt of a continuity of care form from the referring facility, or b) documentation from a pharmacy, or c) current, properly labeled prescription bottles, or d) verification with outside medical records.

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Number: **P0014**
Effective Date: **6/7/06**
Last Revision: **4/10/07**
Title: **Continuation of Psychotropic Medications for Arriving Inmates**

7. The medications can be continued at the same or reduced dosage for up to 28 days. Reducing the dose will not require a non-formulary request. Prescription duration in excess of 28 days will require a non-formulary request form be completed.

8. The prescribing provider shall order no more than the maximum dosage recommended by the FDA for any medication regardless of the amount the inmate was formerly receiving.

9. Increasing the dose of a non-formulary medication above that specified on the verifying documentation acquired by the PN II will require a non-formulary request form be completed.

10. Starting a new non-formulary medication will require a non-formulary request form be completed.

11. Starting, stopping or continuing formulary medications on inmates will not affect the provisions of items 1-10.

12. The PN II shall attach a copy of the means of verification to the prescription sent to the ADC pharmacy.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0015**
Effective Date: **6/7/06**
Last Revision: **4/10/07**
Title: **Management of Benzodiazepine Medications in Arriving Inmates**

Consistent with the psychiatric literature and the experience of the ADC psychiatrists, it is found that benzodiazepine medications are sought and used as drugs of abuse in the correctional setting. This makes their use in the correctional setting hazardous for the inmates to whom they are prescribed as well as to the inmate population as a whole. Therefore, following the consensus of the ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meetings of 7 June 2006 and 17 August 2006, the following guidelines are presented for the management of benzodiazepine medications for inmates arriving at all Arizona State Prison Complexes.

When inmates are seen by a Psychiatrist or Mental Health Nurse Practitioner (P/MHNP):

1. The psychiatric nurse (PN II) shall verify that the inmate is currently taking benzodiazepine medication through one of the following: a) receipt of a continuity of care form from the referring facility, or b) documentation from a pharmacy, or c) current, properly labeled prescription bottles, or d) verification with outside medical records.
2. The P/MHNP shall determine whether the inmate is taking the benzodiazepine medication for the treatment of a medical condition, a mental health condition or for the treatment of both a medical and a mental health condition.
3. For inmates taking benzodiazepine medications solely for the treatment of a medical condition, the inmate shall be referred to the general medical provider for orders.
4. For inmates taking benzodiazepine medications for the treatment of both a general medical condition **AND** a mental health condition, the inmate shall be referred to the general medical provider to have the benzodiazepine managed.
5. For inmates taking benzodiazepines solely to treat a mental health condition, a taper or discontinuation of benzodiazepine shall be ordered by the P/MHNP after the general medical provider clears the inmate medically. Patients whose daily dose is equal to or less than 2mg of clonazepam, 2mg lorazepam, 10mg diazepam, 1mg Alprazolam or the equivalent shall have the medication abruptly discontinued. Inmates on doses higher than those shall have their medication gradually tapered. Clonazepam shall be the sole benzodiazepine medication prescribed. A non-formulary request form shall not be required provided that the taper is scheduled to be complete within 21 days. Prescription duration in excess of 21 days will require a non-formulary request form.
6. The PN II shall attach a copy of the means of verification of benzodiazepine use to the prescription sent to the ADC pharmacy.
7. A medical hold will be placed on inmates until the benzodiazepine taper is complete.

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Number: **P0015**
Effective Date: **6/7/06**
Last Revision: **4/10/07**
Title: **Management of Benzodiazepine Medications in Arriving Inmates**

For inmates who for some reason are not seen by the P/MHNP immediately upon arrival:

1. The psychiatric nurse (PN II) shall verify that the inmate is currently taking benzodiazepine medication through one of the following: a) receipt of a continuity of care form from the referring facility, or b) documentation from a pharmacy, or c) current, properly labeled prescription bottles, or d) verification with outside medical sources.
2. The PN II shall attach a copy of the means of verification of benzodiazepine use to the prescription sent to the ADC pharmacy.
3. Benzodiazepine medication can be continued for up to 7 days without a non-formulary request.
4. Clonazepam shall be the sole benzodiazepine prescribed.

When inmates arrive at ADC on benzodiazepines other than clonazepam, the following conversion formula will be used to calculate the equivalent dosage of clonazepam which they will be prescribed:

BENZODIAZEPINE CONVERSION FORMULA:

CLONAZEPAM 1 mg per day =

ALPRAZOLAM 0.5 mg per day =

LORAZEPAM 2 mg per day =

DIAZEPAM 5 mg per day =

CHLORDIAZEPOXIDE 15 mg per day =

OXAZEPAM 15 mg per day

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0016**
Effective Date: **8/17/06**
Last Revision: **4/10/07**
Title: **Managing Photosensitivity Reactions from Psychotropic Medication**

Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on 17 August 2006 the following guidelines are presented for managing photosensitivity reactions from psychotropic medications:

1) All cases of inmate reported photosensitivity shall be verified by direct clinical examination by the Psychiatrist, Mental Health Nurse Practitioner (P/MHNP), Psychiatric Nurse II or general medical staff. In all cases there shall be documentation of an unequivocal diagnosis of significant sunburn (to include erythema at a minimum), in the medical record or mental health progress notes.

2) If the P/MHNP determines that the inmate's psychotropic medication is contributing to their photosensitivity, the P/MHNP shall meet with the inmate and discuss treatment alternatives including medications having less marked photosensitizing effects.

3) For cases in which the P/MHNP and inmate agree that switching psychotropic medications is not desirable, the inmate will be counseled as to proper use of sunscreen. The P/MHNP will order "sunscreen minimum SPF 30". The sunscreen order will be for 1 bottle per month with adequate refills to supply the inmate from March to October.

4) Inmates will not be issued special duty statuses, special clothing or hats.

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Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0018**
Effective Date: **8/17/06**
Last Revision: **4/10/07**
Title: **Managing Medication Distribution for Inmates Recently on Suicide and Mental Health Watches**

Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on 17 August 2006, the following guidelines are presented for medication distribution to reduce the opportunity for intentional overdoses:

1) Inmates who are put on suicide or mental health watch shall have all their medications dispensed Watch / Swallow (W/S).

2) The Psychologist III or their designee shall notify the Facility Health Administrator (FHA) and Psychiatric Nurse II (PN II) that the inmate has been placed on watch status.

3) The PN II shall write a new prescription changing all the inmate's psychotropic medications to W/S status and document the change on a progress note in the mental health record.

4) The FHA will notify the medical provider that the inmate is on watch status. The medical provider shall have a new prescription submitted to the pharmacy changing all the inmate's non-psychotropic medications to W/S status. The change of medications to W/S status shall be documented in the medical record progress notes. The provider shall write "inmate on watch" on the prescription. An "Exception Request" will not be required.

5) After being taken off of suicide and mental health watch, inmates will continue to receive their medications Watch / Swallow until a multidisciplinary staff team deems the inmate capable of safely self-administering medication.

6) The multidisciplinary team shall consist of a Psychiatrist or Mental Health Nurse Practitioner (P/MHNP), Psychologist II and PN II. The findings of the staff meeting shall be documented in the mental health progress notes. An entry will also be made in the medical section progress notes of the inmate medical record and the record will be forwarded to the general medical provider for review.

7) The multidisciplinary team shall have a staffing within 30 days after the release of he inmate from Watch status to determine if continued W/S administration is necessary. When the team decides to keep an inmate on W/S status, the general

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Number: **P0018**
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Title: **Managing Medication Distribution for Inmates Recently on Suicide and Mental Health Watches**

medical provider shall write "overdose risk by staffing" on succeeding prescriptions. An "Exception Request" will not be required.

8) Inmates who the team decides to keep on Watch / Swallow meds shall have their need for continued Watch / Swallow status assessed by the P/MHNP at each following psychiatric appointment. When the P/MHNP concludes that the inmate is capable of safely self-administering Keep On Person Meds (KOP), they will convene another multidisciplinary staff team meeting as per item 6 above.

9) When the team concludes that the inmate can safely self-administer KOP meds, the respective providers shall submit new prescriptions containing the change to the pharmacy and document the change in their individual progress notes.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0020**
Effective Date: **8/17/06**
Last Revision: **4/10/07**
Title: **Antidepressant Medication Protocol**

Based on the consensus of the ADC psychiatric staff and the Pharmacy and Therapeutics Committee meetings of 8/17/06 and 3/7/07, the following is instructed:

1. All inmates who are prescribed antidepressant medications shall have adequate assessment and monitoring done to ensure that treatment is necessary and effective, in the inmate's best interest, and the possibility of toxic side effects is minimized.

2. Antidepressant medications shall be prescribed by psychiatrists or mental health nurse practitioners who take all customary actions to establish that treatment is necessary including taking an adequate psychiatric history and performing an adequate mental status examination.

3. Psychological testing in consultation with psychology and review of prior ADC and non-ADC medical records and institutional records will occur when necessary to establish the inmate's mental health diagnoses with reasonable certainty.

4. Inquiries as to an inmate's functional status with non-medical correctional staff (such as housing unit, educational, recreation and administrative staff) will occur when necessary to establish an inmate's functional status with reasonable certainty.

5. The prescribing provider shall select the specific antidepressant medication and determine the dose to be used by considering the individual inmate's diagnosis and history and in compliance with the ADC formulary.

6. To be considered a failed trial, all antidepressant medication trials shall be of at least six weeks duration at the target dosage unless limited by unmanageable adverse effects. Trials occurring prior to the inmate's arrival at ADC must be confirmed by outside medical records. Trials which occurred during periods of active alcohol or illicit drug abuse shall not be considered adequate.

7. In some cases (especially involving inmate reports of previous serious adverse reactions) temporary non-formulary approval may be granted for up to 90 days while outside records are obtained. It is the responsibility of the prescribing provider, through an order given to the psychiatric nurse, to notify the Medical Records department that prior records are needed.

8. Lower doses than those in item 9 below shall be used for inmates who respond well to lower doses or who develop adverse effects at higher doses.

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Number: **P0020**
Effective: **8/17/06**
Last Revision: **4/10/07**
Title: **Antidepressant Medication Protocol**

9. Target doses for non-responders without limiting side effects are as follows:

   For fluoxetine 20mg per day (tier 1)
   citalopram 40mg per day (tier 1)
   sertraline 100mg per day (tier 2)
   paroxetine 40mg per day (tier 2)
   desipramine augmentation 50mg per day (tier 2)
   venlafaxine XR 150mg per day (tier 3)

10. For inmates without a history of prior, serious adverse reactions the initial antidepressant medication shall be fluoxetine or citalopram.

11. If the initial agent tried was ineffective or not tolerated, the other medication in item 10 shall be used.

12. If both fluoxetine and citalopram are either ineffective or not tolerated, then sertraline, paroxetine or desipramine may be used. A non-formulary request will not be required. Desipramine may be used alone or in combination with an SSRI. Providers may use agents in tier two without first trying those in tier one if the inmate has a past history of a positive response. A non-formulary request will not be required.

13. If three SSRI's are ineffective or not tolerated, then venlafaxine XR may be used. The maximum dose of venlafaxine XR will be 150mg per day. Higher doses shall require a non-formulary request.

14. Non-formulary medications shall be requested only after three SSRI's and venlafaxine XR have been tried.

15. Prescribing providers shall take reasonable precautions to monitor for the occurrence of adverse effects. Inmates with a history of heart disease or older than 45 years of age shall have an EKG prior to commencing desipramine. Inmates taking more than 100mg desipramine per day shall have a serum desipramine level checked to insure that it is not within the toxic range (above 200ng/ml). Serum desipramine levels will be drawn 10-14 hours after the ingestion of medication and after the inmate has been taking the same dosage for at least five days. Inmates taking more than 50mg per day of desipramine concurrently with medications which could elevate desipramine levels (i.e. fluoxetine, paroxetine) shall have a serum desipramine level checked to insure that it is not within the toxic range (above 200ng/ml). Desipramine will always be dispensed watch / swallow.

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Number: **P0020**
Effective: **8/17/06**
Last Revision: **4/10/07**
Title: **Antidepressant Medication Protocol**

16. Inmates taking more than 50mg amitriptyline per day will have a serum level checked if they are concurrently prescribed fluoxetine, paroxetine or any other psychotropic medication which could inhibit the metabolism of amitriptyline or nortriptyline.

17. The maximum dose of desipramine for use in ADHD will be 150mg per day. Higher oses shall require a non-formulary request accompanied by a serum desipramine level result drawn while the inmate was taking 150mg per day.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0021**
Effective Date: **4/10/07**
Title: **Guidelines for Referral to Psychiatry**

1. Mental Health staff shall refer inmates to psychiatry for further evaluation and/or treatment whenever the following clinical presentation or diagnoses are suspected or evident:

   A. Schizophrenia and other psychotic disorders (Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition). This includes any inmate with delusional beliefs.

   B. Bipolar Disorder.

   C. Major Depressive Disorder With Psychotic Features or Major Depressive Disorder Without Psychotic Features but with moderate to severe symptoms.

   D. Any Clinical Disorder accompanied by suicidal or violent ideation or acts.

2. Mental Health staff may refer inmates to psychiatry for further evaluation and/or treatment whenever the following clinical presentation or diagnoses are suspected or evident:

   A. Major Depressive Disorder with mild symptoms or Depressive Disorder NOS.

   B. Any Anxiety Disorder.

   C. Any Personality Disorder accompanied by suicidal or violent ideation or acts.

   D. Substance-Induced Psychotic Disorder and Psychotic Disorder NOS (isolated complaints of hallucinations in the absence of other indicators of mental illness). These

inmates shall be evaluated by a psychologist prior to referral to psychiatry.

E. ADHD with severe symptoms confirmed by other ADC staff, such as teachers, work supervisors, recreation therapists, housing unit officers.

F. Other inmates as deemed appropriate for referral after staffing by psychology and psychiatry.

3. Mental Health staff shall not refer inmates to psychiatry when the primary complaint is inability to sleep not accompanied by one of the clinical presentations or diagnoses listed in items 1 and 2 above.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0022A**
Effective Date: **4/10/07**
Title: **Voluntary Psychotropic Medication**
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Nothing in this Procedural Instruction shall negate the provisions of Procedural Instruction number 22B, items 1.5 through 1.5.3, nor the provisions of Procedural Instruction Number 22C, items 1.6 through 1.8.2.

1.1 Nothing in this Procedural Instruction shall relieve any staff from responsibility for adhering to Department written instructions.

1.2 When voluntarily administering psychotropic medication, the psychiatrist or Mental Health Nurse Practitioner shall:

1.2.1 Complete the Informed Consent for Psychotropic Medication, Form 1103-12P, and allow the inmate to sign it.

1.2.1.1 This form is to be used at any facility where psychotropic medication is administered for treatment of mental disorders.

1.2.1.2 In the event the inmate refuses to sign the form, the attending staff shall write "refused to sign" on the inmate signature line.

1.2.1.3 If an approved medication consent form specific for the proposed medication is available, is should be utilized in place of Form 1103-12P.

1.2.2 Document, on the Mental Health Progress Notes in the inmate's health record file, the reason for prescribing psychotropic medication, and the dosage and duration of the medication.

1.2.3 Prepare a prescription to dispense psychotropic medication.

1.2.4 Ensure, in conjunction with Pharmacy and Nursing staff, that the inmate receives the psychotropic medication within a medically appropriate time frame.

1.3 Psychiatrists and Mental Health Nurse Practitioners may prescribe psychotropic medication and administer it voluntarily to inmates who are inpatients at the Alhambra Behavioral Treatment Facility if, in their opinion, the medication is necessary for the treatment of a mental disorder.

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Number: **P0022A**
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Title: **Voluntary Psychotropic Medication**

1.4 When voluntarily or involuntarily administering psychotropic medication, the health care professionals responsible for administering the psychotropic medication and documenting compliance with the psychiatrist' or mental health nurse practitioner's prescription for psychotropic medication shall:

1.4.1 Only dispense psychotropic medication that has been ordered in a current prescription by a psychiatrist or mental health nurse practitioner and is labeled.

1.4.2 Copy each medication order onto the Medication Administration Record (MAR).

1.4.3 Complete a laboratory requisition, if indicated.

1.4.4 Bracket, after transcribing the orders, all orders in RED and write "noted," followed by the date, time, the health care professional's legal name and professional title.

1.4.5 Document, on the medication sheet, all psychotropic medication that is administered.

1.4.6 Inform the psychiatrist or mental health nurse practitioner of any adverse reactions to the psychotropic medication, and document the information in the mental health progress notes and on medication sheet.

1.4.7 Keep all psychotropic medication in containers bearing the pharmacist's original label and store it in a securely locked medicine cabinet where the institution's prescription medications are stored and dispensed.

1.4.8 Administer psychotropic medication to inmates by **one** of the following methods, as determined by reviewing the prescription:

1.4.8.1 By unit dose.

1.4.8.2 By daily dose.

1.4.8.3 By watch swallow.

1.4.8.3.1 Any health care professional may place an inmate on watch swallow if he or she suspects that the inmate may not take the medication as prescribed. Watch swallow can only be discontinued with written orders from the psychiatrist or mental

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health nurse practitioner in compliance with Mental Health Procedural Instruction # 18.

1.4.8.4 By keep on person.

1.4.8.5 By intra-muscular injection.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Psychiatry**
Number: **P0022B**
Effective Date: **4/10/07**
Title: **Emergency Involuntary Psychotropic Medication**

Nothing in this Procedural Instruction shall negate the provisions of Procedural Instruction number 22A, items 1.1 through 1.4.8.5, nor the provisions of Procedural Instruction Number 22C, items 1.6 through 1.8.2.

1.5 A Department psychiatrist or mental health nurse practitioner (or another attending physician if a psychiatrist or MHNP is unavailable) may order emergency psychotropic medication for and administer it involuntarily to an inmate with a mental disorder if, after evaluating the severity of the inmate's symptoms and the likely effects of the particular drug to be used, the psychiatrist or mental health nurse practitioner determines that:

1.5.1 An emergency exists in which the inmate's conduct presents a likelihood of imminent serious bodily harm to self or others.

1.5.2 Alternative methods of confinement or restraint are inadequate.

1.5.3 Forced medication is required, as a last resort, to address the emergency.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Suicide Prevention**
Number: **SP0001**
Effective Date: **9/26/05**
Last Revision: **4/10/07**
Title: **Significant Self-Harm Event Review**

The Key Contact Psychologist shall ensure a report is prepared for each significant inmate self-harm event occurring in his/her area of responsibility. Significant self-harm events are defined as:

(1) Events involving potentially lethal methods (e.g., hanging, overdose involving lethal substances).

(2) Events involving methods that were likely to be lethal considering time of day, setting, or degree of staff supervision (e.g., cutting occurring in the middle of the night).

(2) Any self-harm event resulting in medical hospitalization.

Professional judgment and review of other institutional data may be required to make this determination.

Reports on significant self-harm events shall follow the format outlined on the current Significant Self-Harm Report form.

It is the responsibility of the Key Contact Psychologist to review all significant self-harm reports.

Reports on significant self-harm events shall be forwarded to the Mental Health Program Manager and the Mental Health Quality Assurance Program Manager within ten (10) working days from the date of the self-harm event. This turnaround time does not preclude the Key Contact Psychologist from making any interim procedural changes that may be necessary to ensure inmate health and safety.

Any question about whether an event qualifies as a significant self-harm event shall be directed promptly to the Mental Health Program Manager.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: Suicide Prevention
Number: SP0002
Effective Date: 1/12/07
Title: Discontinuation of Suicide and Mental Health Watches
Page 1 of 1

It is the responsibility of the Key Contact Psychologist to ensure that all Mental Health staff are aware of and comply with the following:

1. No suicide or mental health watch shall be discontinued on a Friday, during the weekend, or on the day before a state or federal holiday. This applies to all Fridays and all weekends, not just those associated with holidays. In the rare case that Friday is a state or federal holiday, this directive would apply to the Thursday before the holiday Friday.

2. A suicide watch typically shall not be downgraded to a mental health watch on a Friday, during the weekend, or on the day before a state or federal holiday.

   A. Exceptions to this guideline may be granted on a case-by-case basis by the Mental Health Program Manager or designee.

3. Continuous suicide watches may be downgraded to 10-minute suicide watches on a Friday, during the weekend, or on the day before a state or federal holiday. However:

   A. Only a psychiatric provider or psychologist or other mental health staff in consultation with a psychiatric provider or psychologist shall modify watch status under these circumstances following an in-person evaluation of the inmate on watch.

   B. Downgrading a continuous suicide watch to a 10-minute suicide watch under these circumstances shall only occur:

      -After the inmate has been on continuous suicide watch for a reasonable and clinically appropriate period of time; and

      -The inmate is not actively engaged in self-harm or considered to be at high imminent risk for suicide or self-harm; and

      -The inmate is placed in a designated watch cell, not in a standard cell, holding cell, or enclosure.

Arizona Department of Corrections
Counseling and Treatment Services - Mental Health
Procedural Instruction

Subject: **Levels of Service Delivery**
Number: **TR0001**
Effective Date: **August 1, 2007**
Last Revision Date: **5/18/06**

The purpose of this procedural instruction is to assist in the identification of service levels for inmates identified as needing mental health services.

An inmate identified with a history of a suicide attempt(s) warranting preference to shared housing assignment will be identified with a sub-code of S. This will apply to all inmates having a MH score between 2 and 5.

Mental health needs scores and need levels are to be documented in the mental health file and on AIMS.

Inmates having mental health needs scores of 1 will not have a sub-code.

Mental health staff will adhere to:

(1) Inmates identified with mental health needs will be seen by Mental Health staff within three (3) working days of detention placement.
(2) In a detention setting, inmates identified with mental health needs will be seen at least once every five (5) working days or sooner if clinically indicated.
(3) Inmates submitting a Health Needs Request (HNR) for mental health services will be seen by Mental Health staff.
(4) Inmates identified with mental health needs will receive Arizona Board of Executive Clemency representation upon request.
(5) All contacts identified in the service level section will be documented in the inmate's medical record and correspond to the inmate's treatment plan.
(6) Required service level contacts will not coincide on the same dates for different disciplines.
(7) Inmates will receive services corresponding to their designated Mental Health Score (see revised classification scores memo dated 07/12/07).

MH 5 Service Level – must have an assigned provider

- *Treatment Plan (immediate)*
- *Treatment Plan reviews monthly*
- *Treatment Staffings weekly*
- *Psychiatric contacts a minimum of 2 times per week (psychiatrist/mental health nurse practitioners at least 1 time per week)*
- *Mental Health (to include psychiatry) contacts a minimum of 4 times per week or more often if clinically indicated*
- *After one year of consistent documentation indicating that no overall rapid improvements are likely to occur:*
    - *i. Quarterly treatment plan reviews*
    - *ii. Monthly staffings*

iii. *Psychiatric contacts a minimum of 2 times per week*
iv. *(psychiatrist/mental health nurse practitioners at least 1 time per week)*
v. *Mental Health (to include psychiatry) contacts a minimum of 4 times per week*

MH 4 Service Level – must have an assigned provider

- *Treatment Plan (within 1 week)*
- *Treatment Plan reviews quarterly*
- *Treatment Plan staffing monthly*
- *Psychiatric contacts a minimum of every 4 weeks (psychiatrist/mental health nurse practitioners at least every 8 weeks)*
- *Mental Health (to include psychiatry) contacts a minimum of every 2 weeks or more often if clinically indicated*
- *After one year of consistent documentation indicating that no overall rapid improvements are likely to occur:*
  i. *Quarterly treatment plan reviews*
  ii. *Quarterly staffings*
  iii. *Psychiatric contacts a minimum of every 4 weeks (psychiatrist/mental health nurse practitioner at least every 8 weeks)*
  iv. *Mental Health (to include psychiatry) contacts a minimum of every 2 weeks*

MH 3 Service Level – must have an assigned provider

- *Treatment Plan (within 30 days)*
- *Second and third treatment plan reviews at 6 months each or sooner as clinically indicated*
- *Psychiatrist/ mental health nurse practitioner contacts a minimum of every 3 months or sooner as clinically indicated*
- *Mental Health (to include psychiatry) contacts a minimum of every 4 weeks or more often if clinically indicated*
- *After one year of consistent documentation indicating that optimal treatment response has occurred:*
  i. *Treatment plan reviews yearly, or sooner as needed*
  ii. *Psychiatric contracts a minimum of every 3 months (Psychiatrist/mental health nurse practitioner contact a minimum of 6 months or sooner if clinically indicated.*
  iii. *Mental Health (to include psychiatry) contacts a minimum of every 6 weeks or more often if clinically indicated*

MH 2 Service Level -- No assignment

- *No Treatment Plan.*
- *Services upon HNR or referral.*

MH 1 Service Level -- No assignment

- *No Treatment Plan.*
- *Services upon HNR or referral.*

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Assessment/Treatment**
Number: **TR0002**
Effective Date: **4/10/07**
Title: **Identification and Management of Seriously Mentally Ill (SMI) Inmates**

Seriously mentally ill inmates are those meeting diagnostic criteria reflective of significant impairment in vocational, social and/or daily life skills.

If an inmate has one or more qualifying diagnoses, a provisional SMI determination will be established for the inmate. This determination shall be reviewed based upon new evidence (e.g., diagnostic testing, receipt of prior treatment records) and/or by treatment team consensus.

Inmates previously determined to be SMI in the community mental health system shall also be designated SMI throughout their incarceration in ADC.

Minimum mental health service delivery levels shall be determined by mental health need level (i.e., Routine or Special Need). Mental health need levels are independent of an inmate's designation as SMI, as SMI inmates can be considered to be stable in treatment or not.

The following shall occur for SMI inmates:

1. The inmate's medical file shall be brown-tagged to identify the inmate as SMI.

2. The designation "SMI" shall be placed on the Problem List in Section 1 of the inmate medical record.

3. The designation "SMI" shall be recorded in the mental health database.

4. SMI inmates shall be exempt from medical and mental health charges.

5. SMI inmates shall be referred to community mental health agencies for evaluation prior to release to ensure continuity of mental health care.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Assessment/Treatment**
Number: **TR0003**
Effective Date: **2/9/07**
Last Revision: **4/10/07**
Title: **Medical Record Review for Intra- and Inter-Facility Transfers**

This procedure is intended to ensure that each inmate's medical record shall be reviewed upon arrival at a new complex or unit. This information will be used to alert mental health staff about significant issues for each new inmate.

1.1 Mental Health staff shall review daily all new arrivals at each complex or unit.

1.2 The following, at a minimum, shall be reviewed:

1.2.1 Problem List

1.2.1.1 Current Mental Health Score and Need Level

1.2.1.2 Current mental health diagnoses

1.2.1.3 Suicide attempt history

1.2.1.4 Previous or current SMI status

1.2.1.5 Chronic medical conditions that may affect mental health

1.2.2 Intake mental health assessment(s)

1.2.3 Intake nursing/medical assessment(s)

1.2.4 Continuity of care/transfer summary information

1.2.4.1 Pharmacy profile

1.2.4.2 Jail medical services

1.2.5 Prior treatment records, if available at time of review

1.2.6 Medical section

1.2.6.1 Progress notes from the past year indicating any significant medical issues/chronic conditions that may affect mental health

1.2.7 Health Need Requests

Subject: **Assessment/Treatment**
Number: **TR0003**
Effective Date: **2/9/07**
Last Revision: **4/10/07**
Title: **Medical Record Review for Intra- and Inter-Facility Transfers**

1.2.8 Mental health section

1.2.8.1 Mental health progress notes

1.2.8.2 Current diagnoses

1.2.8.3 Current psychiatric medications, including expiration dates

1.2.8.4 Current Mental Health Score and Need Level

1.2.8.5 Suicide or mental health watch history

1.2.8.6 SMI status

1.2.8.7 Significant behavioral problems

1.2.9 Legal/administrative section

1.2.9.1 INCRs indicating Mental Health Scores and Need Level

1.2.9.2 Administrative psychological evaluations (e.g., Board of Executive Clemency, Interstate Corrections Compact)

1.3 The information from file review shall be available to the Mental Health staff on the inmate's receiving unit within one business day.

1.3.1 Whenever an inmate is identified as having an acute or significant mental health issue, Mental Health staff shall be contacted to assess the inmate immediately.

1.4 The information from the record review shall be documented on a mental health progress note and filed in the mental health section of the medical record.

1.5 Inmates shall be referred for mental health services as follows:

1.5.1 Routine Need inmates shall be seen by Mental Health staff within 14 days of arrival on a new complex.

1.5.2 Routine Need inmates shall be seen by Mental Health staff within three days when placed in a detention unit.

1.5.3 Special Need inmates shall be seen by Mental Health staff within three days of arrival on any new unit.

1.5.4 Inmates with a history of psychiatric medications during the past year in the community, jail or ADC shall be referred to a psychiatric provider.

1.6 Return-to-custody inmates (revoked release violators) shall receive a mental health assessment as soon as feasible but no later than one day after arrival and shall be referred for mental health services as clinically-appropriate and consistent with the guidelines provided in 1.5.2 through 1.5.4.

1.7 Inconsistencies, irregularities or discrepancies arising from the medical record review shall prompt referral to the mental health team on the receiving unit so that the inmate's mental health status can be clarified.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Assessment/Treatment**
Number: **TR0004**
Effective Date: **3/12/07**
Last Revision: **4/10/07**
Title: **Mental Health Treatment Plans for Inmates on Watch**

Mental Health staff shall ensure that any inmate displaying signs or symptoms of mental disorder who is placed on a precautionary suicide or mental health watch shall have an outpatient mental health treatment plan (Form 1103-16P). If the inmate resides in a specialized mental health program, Mental Health Treatment Plan form 1103-4P shall be used.

Until reviewed and revised by Mental Health staff at the receiving unit after the inmate is discharged from watch, this mental health treatment plan shall guide mental health services provided to the inmate.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Assessment/Treatment**
Number: **TR005**
Effective Date: **4/10/07**
Title: **Triage for Health Needs Requests at Reception**

1. Health Need Requests (HNRs) to Mental Health from reception inmates will be reviewed by designated Mental Health staff (excluding psychiatrists and mental health nurse practitioners).

2. Inmates with non-medication issues will be forwarded to appropriate Mental Health Staff (Psychologist or Psychology Associate).

3. Inmates with urgent medication issues (e.g., serious medication side effects) will be seen by psychiatric nursing staff for assessment and triage.

4. Inmates with non-urgent medication issues will be referred to their psychiatric staff at the receiving facility. A mental health progress note will be completed by psychiatric nursing staff documenting this referral and will be placed in the mental health section of the inmate medical record.

   A. "Non-urgent" by definition means issues that can wait until the inmate is seen at the receiving facility (e.g., initiating medications such as mood stabilizers, antidepressants, and antipsychotics, which may require several weeks to exert therapeutic impact so that waiting for the inmate to be seen by the psychiatric provider at the receiving complex is reasonable).

5. Special Handling inmates (who may have extended stays at reception) will be referred to psychiatry for both urgent and routine psychiatry follow up care as deemed necessary by the psychiatric nursing staff triaging the HNRs.

Arizona Department of Corrections
Counseling and Treatment Services
Mental Health Procedural Instructions

Subject: **Administrative**
Number: **AD0002**
Effective Date: **2/09/07**
Last Revision: **4/10/07**
Title: **Mental Health Key Contact Medical Record and Service Delivery Review**

1.1 Each Key Contact Psychologist shall review a minimum of ten (10) medical/mental health records each month randomly selected from the mental health caseload at the complex (i.e., Mental Health Needs Scores of 3 or above).

1.1.1 The Key Contact Psychologist shall review the selected records according to the attached guidelines (Mental Health Key Contact Medical File and Service Delivery Review Form).

1.1.2 The Key Contact Psychologist shall forward copies of all Mental Health Key Contact Medical File and Service Delivery Review Forms to the Mental Health Program Manager by the eighth calendar day of each month.

ATTACHMENT A

Mental Health Key Contact Medical File and Service Delivery Review

KCP Reviewer: _____ **Date of review:** _____

ADC Number: _____ **Complex/Unit:** _____

ITEM	YES/NO/ NA	COMMENTS/CORRECTIVE ACTIONS
SMI inmates have brown tag on file		
Problem List includes current MH Score/Need Level, current diagnosis, SMI status, history of self-harm, IQ <70		
Mental Health Assessment complete, timely, and filed under Problem List		
Serious Mental Illness evaluation filed under Problem List		
Prior mental health treatment records filed		
Refusal of treatment form completed		
Emergent mental health issues on HNRs are responded to as soon possible but no later than within 24 hours		
Non-emergency HNR's responded to within 5 working days		
Current Mental Health Treatment Plan filed on top of Mental Health section		
SOAP notes are chronological, continuous, with no blank space between entries		
SOAP entries are signed, timed and dated, and name stamped by provider		
SOAP entries are legible		
SOAP entries have any errors lined out, "error" noted, and initialed and dated		
SOAP notes contains inmate name, ADC number and location		
Continuation of SOAP entries onto second page are noted, signed, and dated		
Group progress notes are completed and filed chronologically by group ending date		
Record reviews for transferring inmates are accurate and complete		
Informed consents for current psychiatric medications completed		
Psychiatric evaluations completed		
Psychiatric medications are not discontinued or allowed to expire without a face-to-face interview with the psychiatrist or mental health professional in consultation with the psychiatrist.		
Psychiatric nurse noted psychiatrist's orders with name, date, time and name stamp		
Psychological assessment entries are signed/co-signed by a psychologist and include at a minimum identifying information, reason for referral, findings, and recommendations		
Staffing notes completed and filed chronologically		
Mental Health Disposition forms for watches adequately completed		
S section in SOAP includes inmate self-report of presenting problem, including quotations from inmate		
O section in SOAP includes objective findings including mental status exam and psychological testing results		
A section in SOAP includes diagnostic impression and DTO/DTS		
P section in SOAP includes treatment interventions provided, specific directions provided to inmate, and plan for follow-up		
Treatment interventions conform to treatment plan and identified problems.		
MH inmates seen within 3 days of arrival on new unit (for Routine Need inmates this applies only to detention placement)		
Special Need inmates are seen by MH staff once every 30 days		
Special Need inmates in detention seen by MH staff once every 5 days		
Special Need inmates will have Need Level and Tx Plan reviewed every 90 days		
Special Need inmates on meds seen by psychiatry/PRN every 60 days, specifically by psychiatric provider every 90 days		
Special Need inmates not on meds seen by psychologist every 60 days		
Routine Need inmates on meds seen at least every 6 months by psychiatry		
Routine Need inmate tx plans reviewed/updated annually		
RTC inmates seen within 1 day of arrival		
Inmates post-suicide watch seen on 3 separate days first week, then weekly for months, then as needed		
Inmate post-mental health watch only seen once weekly for 4 weeks, then as needed		
Mental Health treatment consent signed and filed at bottom of MH section		
Interstate Corrections Compact and Board of Executive Clemency evaluations filed in Legal/Administrative section of medical record		

Arizona Department of Corrections	Outside (Specialty) Care and Clinics	OPR: Medical Program Manager Auth: rp/cp
Health Services Technical Manual	HSTM Chapter 7 Section 2.0.	Supercedes: Effective Date: May 1, 2007

REFERENCES: NCCHC STANDARD P-A-01
NCCHC STANDARD P-D-05
NCCHC STANDARD P-E-12

PURPOSE: To ensure that the inmate's serious medical needs are met by providing for specialty care beyond the medical capabilities of the prison staff by providing a system of efficient management of requesting, deliberation, monitoring, and tracking proposals for specialty services via outside consultations. This process will aid in ADC's delivery of medical services that are comparable with a community standard of care. Consultations may be performed in-house, at an outside location, or by way of video conferencing / telemedicine.

RESPONSIBILITY: It is the responsibility of the Facility Health Administrator to develop processes for smooth management of specialty clinical support. It is the responsibility of the individual Provider staff to monitor their orders and to ensure successful coordination of local and regional access to community providers for specialty care. It is the responsibility of the attending Physician or Mid-level provider to follow their requests for specialty care to ensure that the needs of the patient are met. It is the responsibility of the Correctional Registered Nurse Supervisor II to monitor nursing staff compliance.

PROCEDURES:

1.0. General Authorities:

1.1. Facility Health Administrator: It is the responsibility of the FHA to ensure that all requests for medical services submitted to the Medical Review Committee (MRC) are accurate and complete. The FHA neither approves nor denies any requests for medical services.

1.2. Key Contact Provider: It is the responsibility of the KCP or designee to ensure that the request for approval of medical services is based upon sound medical necessity.

1.3. Clinical Coordinator (CC): It is the responsibility of the CC to forward requests that have been approved by the MRC to the Central Office Medical Review Board (MRB) for final decision on any request. The CC is also responsible for all travel arrangements,

medical holds, and appropriate documentation preparation to accompany the inmate for any consultations.

2.0. Medical Review Committee:
2.1. The membership consists of the FHA and the KCP or designee, all medical providers, and the Clinical Coordinator. In an urgent case, the minimum quorum will be the FHA and KCP. The MRC will meet at least every two weeks to discuss requests for consultation or services. All requests for specialty or outside of ADC healthcare services must be submitted to the MRC on the Consultation Report form #70400064.

2.2. At the time of approval by MRC and submission to MRB, a case appropriate medical hold will be placed on the AIMS system in accordance with HSTM guidance and complex procedures to guarantee that the inmate is not moved to another facility prior to disposition of the request and to allow for receipt of desired services for approved requests. This information and the request will be forwarded for further consideration from the Central Office Medical Review Board (MRB). Requests that are approved by MRC following discussion are entered into a database by the CC. The database is reviewed periodically (at least weekly) by the CC for review of decisions made by MRB and assurance that appropriate result feedback is received and provided to the appropriate complex health services staff.

2.3. The HROD shall ensure each complex MRC complies with Department Orders and Health Services Bureau Technical Manual guidance and shall ensure further consistency in the procurement of health related goods and services delivered to the inmate population among complexes within the region.

2.4. The review shall be accomplished by utilization review, ratio of referrals to inmate population, prison comparisons and the review of current monthly reports, which are produced at the facility level. The statistics are then compiled and distributed to the Facility Health Administrator by the Health Services Bureau Administrator.

3.0. Medical Review Board (MRB): The Medical Review Board consists of the Medical Program Manager. Also included are all clinical program managers and Health Services Coordinator. In an urgent case, the minimum quorum will be the Medical Program Manager.
3.1. Only the Medical Program Manager (or specified designee) may deny any request that has been approved by MRC.

4.0 Medical Records and Documentation Requirements are set to ensure that pending appointment information is transferred from the sending facility to the receiving facility.
4.1. The Correctional Registered Nurse Supervisor II (CRNSII) will monitor nursing staff for ensuring that systems are in place and followed to inform and convey inmates to specialty appointments. In addition, the CRNS II shall coordinate the necessary in-service training to accomplish this process in an accurate and timely manner.

5.0. Medical Record Scheduled Appointment Form will be used for Outside Referrals.

5.1. Form Management—on-site specialty appointments: Inmates are to be scheduled for appointments as indicated by the specific discipline providing the required service or exam. Upon completion of the scheduled appointment any subsequent appointment that is scheduled shall be noted in the appropriate health unit appointment book. The scheduled appointment shall be noted on the "Scheduled Appointment" form.

The form shall note: the date the inmate was seen; the date of the scheduled appointment; the appointment location; the appointing discipline; and the indicating reason for the specific health care appointment.

5.2. In the event that an appointment is to be scheduled and there are compelling reasons that in cannot be scheduled at the time of the initial appointment, columns as noted in the paragraphs above shall be completed. The author of the initial appointment or the staff member noting the order shall document in the progress note the reason for the postponement of the next scheduled appointment.

5.3. When the determination has been made that the appointment, as noted above, is to be made; a member from the respective discipline shall place the appointment date in the unit appointment book and on the Scheduled Appointment form.

5.4. Upon completion of the scheduled appointment the actual date the inmate was seen shall be noted in the "Date Seen" column.

5.5. If the initial date of the scheduled appointment is changed the unit appointment book shall reflect the rescheduled date. In addition "Rescheduled" shall be noted in the "Date Seen" column of the Scheduled Appointment form and a new and total entry shall be completed.

6.0. Form Management--Community Appointments: Upon the clinical coordinator's receipt of the Medical Review Board's approval of an outside consultation, the clinical coordinator shall: Arrange for the outside appointment as directed by local post orders; and contact the sending medical unit nursing staff with the specific information as outlined in this document; and the unit nursing staff are responsible for the completion of form.

7.0. The nurse noting the orders of the medical provider is responsible to enter the proper information into the column noting the actual date the inmate was seen upon the inmate's return from the outside consultation; subsequent follow-up appointments on or off the prison complex must be documented as directed in this document. The Scheduled Appointment form shall be maintained as the top document in section number one.

ARIZONA DEPARTMENT OF CORRECTIONS

☐ Approval Requested ☐ Pre-Approved *(Local Approved)* ☐ Resubmit

Outside Consult Request/Medical Review Board

Type of Consult *(Be Specific)*	Follow Ups Required? ☐ Yes ☐ No Number of Follow Ups _____	Release Date
Medical Reason for Referral		Telemedicine ☐ Yes ☐ No
Medical Allergies	Current Medications	
Problem List *(Chronic/Acute)*		
Subjective Complaints		
Objective Findings		
Medical Treatment Provided on Site to Date		
Questions for Consultant		
Ordering Physician		Date

Local MRB Decision *(If Applicable)* ☐ Approved ☐ Denied ☐ Provider to Supply more information

Approval - KCP/Designee/Provider	Date
Review - FHA/Designee	Date

Sent to Central Office ☐ Yes ☐ No Date _____

Lab Work Attached ☐ Yes ☐ N/A

Test Results Attached ☐ Yes ☐ N/A

Central Office Approval ☐ Yes ☐ No ☐ Resubmit		Authorization Number*
Date and Place of Appointment*	Social Security Number	PID Number

** No appointments are to be scheduled without Authorization Number*

Inmate Name *(Last, First M.I.)*	Inmate Number
Date of Birth	Facility/Unit

Outside Consult Request/Medical Review Board

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Abacavir	Ziagen	300mg Tablet	300mg BID	
Abacavir/Lamivudine	Epizicom	600mg/300mg	1 qd	
Abacavir/Lamivudine(3TC)/Zidovudine(AZT)	Trizavir	300mg/150mg/300mg Tablet	1 BID	
Acetaminophen	Tylenol	325mg Tablet #24 OTC package	MAX 4gm/day	
Acetaminophen	Tylenol	325mg,500mg Tablet/Caplet	325-650mg Q 4 h PRN, 1000mg q6h prn, MAX 4g daily	
Acetaminophen with Codeine	Tylenol #3 Codeine	300mg/30mg Tablet	1-2 tablet q 4 h PRN, MAX 4g/ day APAP	Schedule III (Acute Use 7 Days Only) > 7d requires NF
Acetaminophen with Codeine Elixer	Tylenol with Codeine Elixir	300mg/30mg per 12.5ml U/D	15ml q 4 h PRN, MAX 4g/day APAP	Schedule IV (Acute Use 7 Days Only) ENT Only >7d requires NF
Acetazolamide	Diamox	250mg Tablet	MAX 250mg po QID	
Acetic Acid Otic	Vosol	2% Solution , 15ml	Insert moistened wick X 24 h, then 5 gtts 3-4 X QD	
Acetic Acid, Aluminum Acetate Otic	Domeboro	2% Otic Solution, 60 ml	4-6 gtts q 2-3 h	
Acetic Acid, Hydrocortisone Otic	Vosol Hc	2%/1% Solution 10ml	Insert moistened wick X 24 h, then 5 gtts 3-4 X QD	
Acyclovir	Zovirax	200mg Capsule 800mg Tablet	1 q 4 h W.A. 5/day X 10 Days	Herpes acute use - initial Rx plus one refill in 6 month period. Ointment Is Non-Formulary.
Albuterol	Ventolin, Proventil	2mg, 4mg Tablet	2-4mg 3-4 Times QD	
Albuterol Inhalation Solution	Proventil, Ventolin	0.5% 20ml Solution	2.5mg 3-4 times daily by nebulization	Dilute with sterile NS
Albuterol Oral Inhaler	Proventil, Ventolin	17gm oral inhaler	1-2 puffs q4-6h	
Allopurinol	Zyloprim , Lopurin	300mg Tablet	100mg to 300mg QD pc	
Aluminum Acetate	Burow's, Domboro	Powder/tablet for Solution	1 Packet in pint of water: Apply q 15-30 min for 4-8 h	
Aluminum Hydoxide gel	AluCap	400mg Capsule	Titrated	Restricted to order by specialist - attach consult copy to rx
Aluminum/ Magnesium Hydroxide With Simethicone Susp.	Maalox Plus, Mylanta II	355ml, 150ml	30ml po q 4 h PRN	Acute Use = No Refills -Exception mental health rx
Amantidine	Symmetrel	100mg Capsule	Type A Flu: 1-2 QD X 5-7d for tx 21d or longer for prophylaxis	
Amiodarone	Cordarone, Pacerone	200, 400mg Tablet	400mg/day after initial loading doses	Restricted to specialist order- attach consult copy to rx

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Amitriptyline	Elavil	10, 25, 50, 75, 100, 150mg Tablet	10 -150mg/day	Restricted to medical use- Watch swallow only
Amlodipine	Norvasc	2.5, 5, 10mg Tablet	2.5 - 10mg/day	Restricted to related specialist order - attach copy of consult to rx
Ammonia, Aromatic 0.33ml	Smelling Salts	Covered Nasal Ampule Inhalants	Carefully Inhale Through Nostrils	
Amoxicillin	Amoxil	250mg, 500mg Capsule	1 q8h	
Amoxicillin	Amoxil	500mg Capsule #21	1 q8h	
Amphotericin B For Injection	Fungizone	50mg/15ml Vial	Never More Than 1.5mg/kg/day	Administer Per Mfg's Instructions
Amprenavir	Agenerase	150 mg Capsule	1200 mg BID or 600mg + 100mg ritonavir BID or 1200mg + 200mg ritonavir QD	
Analgesic Ear Solution	Auralgan	10, 15ml	1-2 gtts Q 1-4h PRN	
Aripiprazole	Abilify	5, 10, 15, 20, 30mg Tablet	10-15mg /day	3rd line- Must Follow Antipsychotic Algorithm- Restricted to use after failure of risperidone & typical trial (4 weeks at target dose)
Aspirin	Aspirin	325mg Tablet	MAX 6g Daily	
Aspirin	Bayer, etc	325mg Tablet #24 OTC package	MAX 6g Daily	
Aspirin Enteric Coated	ASA-EC, Ecotrin	81mg,325mg Enteric Coated Tablet	1-2 Q4h PRN Pain , HA / 1qd ,cardiac	
Aspirin, Acetaminophen, and Caffeine	Excedrin Migraine	250mg/250mg/65mg Tablet	2 tablets	
Atazanavir	Reyataz	100, 150, 200mg Capsule	400mg QD in naïve pts or 300mg + 100mg ritonavir QD	Do not take with antacids
Atenolol	Tenormin	50mg, 100mg Tablet	50-100mg QD 50-100mg QD	Check BP and Pulse Monthly
Atorvastatin	Lipitor	10, 20, 40, 80mg Tablet	10 - 80mg/day	Restricted to use after failure of lovastatin
Atropine Ophthalmic	Atropisol Isopto Atropine	0.5%, 1%, 2% Solution	1-2 gtts up to TID	
Atropine Ophthalmic Ointment	Atropisol Isoptoatropine	1% Ointment 3.5g Tube	0.3-0.5cm Under Lower Eye Lid up to TID	
Azathioprine	Imuran	50mg Tablet	Varies with indication	
Azithromycin	Zithromax	250, 500, 600mg Tablet	CAP 500 mg day 1 then 250 mg days 2–5, MAC PX 1200mg/week, 1 g po x 1(Chlamydia)	Restricted to CAP per guidelines and MAC PX & TX Pregnant Females with Chlamydia
Bacitracin Ophthalmic Ointment	Bacitracin Ophthalmic Ointment	500u/g 3.5g Tube	Small Amount Under Lower Eye Lid 1 or More X QD	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Bacitracin/ Neomycin/ Polymyxin-B Ointment	Neosporin	15g Tube	Apply to Affected Area TID for Simple Abrasions, Irritations	
Beclomethasone (Micronized) Oral Inhaler	Q-Var	7.3g Inhaler	40-320mcg 2 Times a Day	
Belladonna Alkaloids with Phenobarbital	Donnatal	0.125mg/16 mg Tablet	1-2 Tablets 3-4 Times Daily	
Benzocaine	Americaine	5% Ointment,cream 15g Tube	Gently Rub in Sparingly 3-4 Times QD	
Benzocaine Dental Gel	Ora-Gel, Orabase	7-10g Tube	Apply Lightly to Affected Area PRN	
Benzoin Tincture	Benzoin	1	Apply Lightly to Intact Skin as Protectant, Air Dry	
Benzoyl Peroxide 10%	OXY-10	45g or 60ml Gel or Lotion	Apply Lightly BID P Cleansing & Drying; Use Sunscreen During Day	1 tube = No refills
Benztropine	Cogentin	1mg Tablet 2mg Tablet Inj. 1mg/ml 2ml Ampule	1-4mg Daily or Twice Daily 1-4mg IM Daily or Twice Daily	First line for EPS up to 6mg/day - may use 1mg bid x 30days for prophylaxis when starting or increasing conventional high potency antipsychotics
Bethanechol	Urecholine	10, 25, 50mg Tablet	10-50mg 3-4 Times Daily	
Bisacodyl	Dulcolax	10mg Suppository 5 mg Enteric Coated Tablet	1 Supp Rectally HS 1-3 Tabs HS:pre-op MAX 6 Tabs HS	Do Not Chew
Bismuth Subsalicylate	Pepto-Bismol	262mg Chew Tablet	2 Tab MAX 8 tablets/24 H	Contains Salicylates: Potentiates ASA, Acute Use = No Refills H Pylori Treatment
Brimonidine Ophthalmic	Alphagan	0.2% 5, 10, 15ml	1 drop affected eye(s) TID	Restricted to order by specialist - attach consult copy to rx
Brinzolamide Ophthalmic	Azopt	1% 5ml,10 ml, 15 ml	1 drop affected eye(s) TID	Restricted to order by specialist - attach consult copy to rx
Bromocriptine	Parlodel	2.5mg	1.25mg po bid initially titrate q 2wks	
Buspirone	BuSpar	5, 7.5, 10, 15, 30mg Tablet	15-60mg/day in 2 divided doses	
Butoconazole Vaginal Cream	Femstat	2%, 28g Tube	1 Applicator (5g) per Vag HS X 3-6d	
Calamine Lotion	Calamine Lotion	120 ml	Apply PRN	Acute Use = No refills
Calcitriol oral	Rocaltrol	0.25, 0.5mcg Capsule	0.25 -2mcg/day	Restricted to order by specialist - attach consult copy to rx
Calcium Carbonate	Rolaids, Tums	500mg, 650mg tablets	1-3 Tabs 2-4 Times Daily	Antacid acute use no refills - Exception mental health rx
Calcium carbonate with Vitamin D	Oystcal D	500mg/200iu	1-2 tablets bid	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Candida Extract	Candida Extract	1	1	For Testing Immune Response in Certain Inmates
Capsaicin	Zostrix	Topical	Apply to Affected Area TID (MAX QID)	
Captopril	Capoten	12.5, 25, 50, 100 mg	12.5-50 mg BID -TID	MAX of 450 mg/day
Carbachol Ophthalmic	Isopto Carbachol	1.5% Ophthalmic Solution 15 ml	1-2 gtts Q 4-8 H	
Carbamazepine	Tegretol	200 mg	400-1200mg QD in Divided Doses	
Carbamide Peroxide Oral	Gly-oxide	10% Oral Solution 60ml	Several Drops to Affected Area PC and HS or 10 gtts Swished X 1-3 Min,	Acute Use = No Refills
Carbamide Peroxide Otic	Debrox	6.5% 15 ml Otic	5-10 drops in affected ear(s) x 15 MIN BID x 4 DAYS	Acute Use = No Refills
Carbenicillin	Geocillin	382mg Tablets	1-2 QID X 10 Days	
Carbidopa/levodopa	Sinemet	10/100mg Tablet 25/100mg Tablet 25/250mg Tablet	1 4-6 Times Daily	
Carvedilol	Coreg	3.125, 6.25, 12.5, 25mg Tablet	3.125- 25mg BID -MAX dose 50mg BID	Restricted to specialist order- attach consult copy to rx
Castor Oil	Castor Oil	30ml U/D	30ml po PRN Acute Constiptaion	One Dose Only
Cefazolin Injection	Ancef	500mg, 1 g Inj	500mg-1gm Q 8H IM/IV	
Ceftriaxone Injection	Rocephin	250mg, 500mg, 1gm, 2gm Vial for inj.	CAP 1gm IM q24h, 250mg IM Single Injection N. Gonorrhea Urethritis	Restricted to CAP and gonacoccal ethritis
Cephalexin	Keflex	250mg Capsule 500mg Capsule	1-2g QD, Divided Doses	
Cephalexin	Keflex	500mg Capsule #28	1-2g QD, Divided Doses	
Charcoal Activated	Acta-Char	260mg Capsule 50g, 120ml Suspension with Sorbitol	1-4 g TID PC Antidote 30 to 100g	Colostomy Patients or Poisoning/overdoses only
Chlorambucil	Leukeran	2mg	Individualized	
Chlorhexidine Gluconate	Peridex	0.12% Oral Rinse 480 ml	15ml Rinse X 30 Sec. BID after Brushing *Not for Ingestion	Restricted to dental use - Keep in health unit
Chlorpheniramine	Chlortrimeton	4 mg Tablet	MAX 24 mg per Day in Divided Doses	Acute Use = No Refills
Chlorpromazine	Thorazine	10, 25, 50, 100, 200mgTablet, 100mg/ml Concentrate 240ml	50-1000mg po Daily	Concentrate: Dilute Just Prior to Administration in minimum 60ml
Chlorpromazine Injection	Thorazine	25mg/ml Inj.ampule	25-200mg Deep IM	Causes Hypotension: Keep Patient Recumbent for 30 Minutes
Cholestyramine	Prevalite	5g	5-10 g MAX TID,mixed W/beverage	
Cilostazol	Pletal	50, 100mg Tablet	50-100mg BID on an empty stomach	Restricted to specialist order- attach consult copy to rx

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Cinacalcet	Sensipar	30, 60, 90mg Tablet	30 - 180mg/day	Restricted to specialist order -attach consult copy to rx
Ciprofloxacin	Cipro	250, 500, 750mg Tablet	250-750mg q12h	Restricted to osteomyelitis, pseudomonas by C&S, otitis media, prostatitis Tx failures and 2nd line UTI
Ciprofloxacin Opthalmic	Ciloxan	0.3% 2.5ml, 5 ml	I-2 gtts q2hr while awake x2 days, then q4hr wa 5 days	Restricted to specialist order- attach consult copy to rx
Citalopram	Celexa	10, 20, 40mg Tablet	20-40mg/day	First line -Note: Concurrent Use of an SSRI with Any Other Antidepressant Requires That an approved NF- Tricyclic Antidepressants, Trazodone, or Other Antidepressants Will Not Be Instituted as Initial Therapy with an SSRI.
Clarithromycin	Biaxin	250, 500mg Tablet	CAP 250-500mg q12h , H-pylori 500mg bid	Restricted to CAP and H-pylori per treatment guidelines
Clindamycin	Cleocin	150 mg Caps	600mg 1H Before Dental Procedure	For SBE Proph. 2nd Line Therapy for PCN Allergic pt and MRSA 3rd line for sulfa allergic pt
Clindamycin	Cleocin T	1% Topical Solution, 60ml	Topically Dabbed on Cleaned, Dried Area BID	-Unit Dose Only- Flammable 2nd Line Therapy
Clobetasol	Temovate, Cormax	0.05% cream and ointment	Apply sparingly 2 to 3 times daily	
Clonazepam	Klonopin	0.5,1, 2mg Tablet	usual target 1mg/day, MAX 4mg/day	Restricted to psych for up to 7-day continuation and up to 21 day taper for patients arriving on benzodiazepines per protocol
Clonidine	Catapres	0.1mg Tablet	opiate withdrawal per protocol	Restricted to use for opiate withdrawal
Clopidogrel	Plavix	75 mg Tablets	75mg QD	Restricted to specialist order -attach consult copy to rx
Clotrimazole Cream	Mycelex	1% Cream, 15 or 30g tubes, 10ml solution	Topical Applications BID	
Clotrimazole Troche	Mycelex	10mg Troche	Dissolve 1 Troche po 5 Times Daily	
Clotrimazole Vaginal	Gyne-LotrImin Mycelex-G	100mg Tablet-7's, 1% Cream-45g	1 Tab/Applicator Vag. HS X 7 D.or 2 TabVag. QHS X 3d	
Clove Oil	Clove Oil	7ml Vial	Apply 1-2 gtts PRN Toothache	Keep in Health Unit
Clozapine	Clozaril	12.5, 25, 100mg Tablet	Initial 12.5mg bid & titrate to 300-450mg/day	Restricted to use at Baker, Flamenco & MTU per protocol
Coal Tar Shampoo	Coal Tar Shampoo	120ml	Shampoo 2x/week at First, Then less Often PRN	1 bottle per month not approved for dandruff

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Coal Tar Solution	Psorigel, 7.5%, T-gel	120g	Apply 1 to 4 Times Daily	
Coccidioidin Test	Spherulin	1:100, 1ml Md	0.1ml Intradermally	
Colchicine	Colchicine	0.6mg Tablet	1-2 Tab Q 1-2h, MAX 4-8mg per Attack	
Cold Sore Balm	Carmex, Herpecin	2.8g Tube	Apply to Cold Sore QID PRN	Acute Use = No Refills
Cromolyn Nasal	Nasalcrom	13 ml Solution	1 or 2 Sprays in Each Nostril QID	
Cyanocobalmin Injection	Vitamin B12 Injection	100mcg/ml-1ml Vial, 1000 mcg/ml MDV	100-1000 mcg IM Q Month	
Cyclobenzaprine	Flexeril	10mg Tab	10mg TID	MAX 14 days Tx per 12 weeks
Cyclopentolate Ophthalmic	Cyclogyl	1%, Solution 2ml	1-2 gtt, 40-50 Minutes Before Exam	
Cyclophosphamide	Cytoxan	25mg Tablet	50-300mg QD Initial, Then Adjust to Response And Condition	Use with Protocol or Consultant Recommendation
Cyclosoprine	Sandimmune, Neoral, Gengraf	25, 100mg Capsule	3 - 10mg/kg/day maintenance	Restricted to specialist order -attach consult copy to rx
Cyproheptadine	Periactin	4mg Tablet	4-20mg/day	Restricted to chronic urticaria
Delavirdine	Rescriptor	100, 200mg Tablet	400mg TID	
Desipramine	Norpramin	25mg,50mg 75mg,100mg Tab	MAX 300mg	Watch Swallow - Medical use: for Neuropathic Pain -Psych 3rd line antidepessant No NF Required following adequate trial of fluoxetine & citalopram (6 weeks)
Dexamethasone	Decadron	0.5mg Tablet	0.5mg Q6h X 48h or 1mg @ 11pm/c Serum Cortisol	Dexameth Suppression Test or specialist order - attach consult copy to rx
Dexamethasone Ophthalmic	Dexair, Maxidex Decadron	0.5% Ointment 3.5g Tube, 0.1% Susp./1 gtt Q4h Soln. 5ml	Small Amount under Lower Eyelid 1-2 times daily, 1 gtt Q4h	
Dexamethasone, Neomycin, Polymyxin	Maxitrol, Dexacidin	1%/0.35%/10000u /ml, 5ml Ophth. Sus.	1-2 gtts BID to QID	
Dextrose 50%		50ml Vial	10-25g IV, Repeat PRN for Insulin Shock	
Diazepam Injection	Valium	10mg/2ml Vial	5-10mg Slow IV, 5mg/min, In 10-15 Min. MAX 30mg	For Use in Seizure Only Schedule IV Drug
Diazepam Rectal	Diastat	10, 15, 20mg kits	weight based per status epilepticus guidelines	Restricted to status epilepticus per guidelines
Dibucaine Cream	Nupercainal,	Rectal, 0.5% 45g Tube	BID and after BM; MAX 30g /24hr	
Dibucaine Ointment	Nupercaine	1%, 30g Tube	Lightly to Affected Area PRN	
Diclofenac sodium	Voltaren	25, 50, 75mg delayed release Tablet	100-200mg/day in divided doses (BID)	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Dicloxacillin	Dynapen	250mg Capsule, 500mg Capsule	250-500mg Q6h x 10-14 days	
Dicyclomine	Bentyl	10mg capsule, 20mg tablet	1-2 QID	
Didanosine DDI	Videx	125, 200, 250, 400mg EC caps	400mg QD (<60kg 250mg QD)	
Digoxin	Lanoxin	0.125mg Tablet 0.25mg Tablet, 0.5mg/2ml Ampule	0.125 to 0.375mg QD, 10 mcg/kg IV over 5 Min, Then 2.5 mcg/kg at 4-8 H Interval	
Diltiazem	Cardizem	30, 60mg Tablet	MAX 240mg QD in 3-4 Doses, Ac & HS	
Diltiazem ER	Cardizem CD	120,180,240mg ER	MAX 360 mg QD	
Diphenhydramine inj	Benadryl	50mg/ml Injection	25-50mg IM or IV	
Diphenhydramine oral	Benadryl	25, 50mg Capsule	MAX 100mg/day	For Psych use only: Second line for EPS up to 100mg/day- after failure of benztropine trial
Diphtheria, Tetanus Toxoids	Dip/Tet, DT	Adsorbed,Adult, 0.5ml	0.5ml, Deep IM,repeat in 4-8 Week and 6-12 Mo after 2nd Dose	
Docusate Sodium	Colace	100mg Capsule	100 to 400mg QHS	
Dome Paste	Unna's Boot	3" or 4" Rolls		
Dorzolamide	Trusopt	2% 5 or 10ml	1 gtt in affected eye TID	Restricted to specialist order- attach consult copy to rx
Doxepin	Sinequan	10, 25, 50, 75, 100, 150caps	10-150mg/day in sigle or divided doses	Restricted to chronic urticaria unresponsive to cyproheptadine
Doxycycline	Vibratabs 100, Vibramycin, Periostat	100mg 20mg	1 BID X 7-10 Days	Periostat Restricted to Dental Use Only
Efavirenz	Sustiva	200mg Capsule, 600mg Tablet	600mg HS	
Efavirenz/Emtricitabine/Tenofovir	Atripla	600mg/200mg/300mg	1 qd	
Emtricitabine	Emtriva	200mg Capsule	200mg QD	
Emtricitabine/Tenofovir	Truvada	200mg/300mg	1 qd	
Emtricitabine/Tenofovir	Truvada	200mg/300mg tablet	1 QD	
Enalapril	Vasotec	2.5mg, 5 mg 10 mg, 20 mg Tablet	10-40 mg QD	
Enfuvirtide	Fuzeon	90mg/ml Vial	90mg SQ BID	Requires NFR
Epinephrine Injection	Adrenalin	1:1000(1mg/ml),1ml Ampule	0.1-0.5mg Sq MAX 5mg/24 Hr	
Ergotamine	Cafergot	1mg/100mg Tablet, 2mg/100mg Suppository	2 tabs at Onset, 1 Q 30 Min Til relief MAX 6 per Attack or 1 supp Q H MAX 2 per Attack	No More than 6/attack or 10 per Week
Erythromycin	Erytab, E-Mycin	333mg Tablet #21	1 tid	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Erythromycin	Ery-tab,E-mycin	333mg Tablet, Enteric Coated	1 TID	
Erythromycin 2%	Eryderm, Staticin	Topical Solution, 60ml	Apply Thin Film to Cleansed and Dried Area BID	-Unit Dose Only- flammable
Erythromycin Ophthalmic	Ilotycin	2% Ointment, 3.5g Tube	Small Amount under Lower Eyelid 1 or More X QD	
Erythropoetin	Epogen, Procrit	2000, 4000, 3000,10000, 20000 units/ml	Titrated SC or IV	Restricted to specialist order -attach consult copy to rx
Estrogens, Conjugated	Premarin	0.3mg, 0.625mg, 1.25mg Tablet, Vaginal, 0.0625%, 45g Tube	0.3 to 1.25mg or More QD in a Cyclic Regimen, 2-4g Vaginally or Topically QD Cyclic Regimen	Female Use Only
Estrone (Estropipate)	Ogen	1.25mg Tablet	0.625mg-5mg Cyclic Adjusted to Tolerance and Response	Female Use Only
Ethyl Chloride		Spray-topical		Keep in health unit
Eye Irrigation	Dacriose, Eye Stream	Solution, 120ml	Irrigate as Needed	
Famciclovir	Famvir	500mg	500mg Q 8 Hrs X 7 Days	Second Line after Capsaicin Failure, for Post Herpetic Neuralgias, Limited to 7 Days
Famotidine	Pepcid	20mg, 40mg Tab	20-40mg QD	
Ferrous Gluconate	Ferrous Gluconate	325mg Tablet	1 TID with Meals MAX 6 Months	
Finasteride	Proscar	1, 5mg Tablet	5mg/day	Restricted to specialist order -attach consult copy to rx
Finasteride	Proscar	5mg Tablet	5mg/day	Restricted to use after failure of terazosin (max tol dose x 3months minumum)
Fluconazole	Diflucan	50,100,150,200mg	Varies by condition from 150mg x1 to 50-800mg/day	Not for onchomycosis - UD/WS for cocci
Fluocinonide	Lidex	0.05% Cream, 30g Tube 0.05% Ointment, 15g Tube 0.05% Solution, 20ml	Apply Thin Film Sparingly 3-4 Times QD	Not to Be Used on Face or Genitalia
Fluorescein Ophthalmic	Fluor-I-Strip	Strips, 1mg	Moisten with Sterile Solution, Touch Fornic, Blink	
Fluorouracil	Efudex	5% Cream 25g Tube, 2% & 5% Soln 10ml	Individualize	Keep in Health Unit/Restricted to order by specialist - attach consult copy

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Fluoxetine	Prozac	20 mg Caps/tabs	20-60 mg Q am	First line -Note: Concurrent Use of an SSRI with Any Other Antidepressant Requires an approved NF- Tricyclic Antidepressants, Trazodone, or Other Antidepressants Will Not Be Instituted as Initial Therapy with an SSRI.
Fluphenazine	Prolixin, Permitil	1mg, 2.5mg, 5mg, 10mg Tablet	5mg to 40mg per Day	
Fluphenazine Decanoate	Prolixin-D	25mg/ml-1ml Syringe, 25mg/ml-5ml MDV	Per mental health procedural instruction #10	Per mental health procedural instruction #10
Fluphenazine Injection	Prolixin	2.5mg/ml 10ml Vial	1/3 to 1/2 Po Dose IM	
Folic Acid	Folic Acid	1mg Tablet	0.25 to 1mg QD or Higher	
Fosamprenavir	Lexiva	700mg Tablet	1400mg BID or 700mg + 100mg ritonavir BID or 1400mg + 200mg ritonavir QD	
Furosemide	Lasix	20mg, 40mg, 80mg Tablet 40mg/2ml Vial	Edema; oral 20-80mg/day or higher -IM/IV 20-40mg or higher. HTN; 40mg BID	IV Given over 1-2 Minutes- High dose at < or = 4mg/min
Gemfibrozil	Lopid	600mg Tab	600mg BID AC	1st line for elevated triglycerides
Gentamicin Injection	Garamycin	40mg/ml,2ml Vial	80mg IM TID (If No Renal Impairment)	Restricted to IPC's
Gentamicin Ophthalmic	Garamycin	0.3% Ointment 3.5g Tube 0.3% Solution, 5ml	Oint:Small Amount under Lower Eyelid 2-3 X daily, Sol'n:1-2 gtts Q h to QH	
Gentamicin Topical	Garamycin	0.1% Cream 15g Tube, 0.1% Ointment, 15g Tube	Apply Small Amount Gently to Cleansed Area 3-4 x QD	
Glucagon Injection	Glucagon	1 Unit Vial for Injection	SQ, IM, or IV 0.5-1mg, may repeat in 5-20 Min. X 2.	If Not Awake after 3 Doses, must Give Dextrose IV
Glucose Tablets/gel	Glucose Tablets	6 per Box/Tube	1 dose for Hypoglycemic Event	
Glyburide	Micronase, Diabeta	2.5 mg Tablet	1.25-20mg in single or divided doses	
Guaifenesin Dextromethorphan	Robitussin DM	100mg/15mg per 5ml Syrup, 120ml	1-2 Tsp Q 4-8H with Water	Acute Use - One bottle -No Refills
Guanfacine	Tenex	1, 2mg Tablet	1-2mg/day	
Haloperidol	Haldol	0.5mg, 1mg, 2mg, 5mg, 10mg, 20mg Tablet	Individual Requirements up to 100mg QD : May be used by medical as anti-emetic at 1-2 mg	
Haloperidol Decanoate	Haldol-D	50mg/ml,ml Ampule	Per mental health procedural instruction #10	Per mental health procedural instruction #10
Haloperidol Injection		5mg/ml, 1ml Ampule	100mg MAX per Day IM : May be used by medical as anti-emetic at 1-2mg	
Hemorrhoidal Anesthetic Cream	Anusol	30g Tube	Apply Rectally TID PRN	Acute Use = No Refills

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Hemorrhoidal Cream with Hydrocortisone		1.0%,30g Tube	Rectally AM & HS x 2-6 Days	Acute Use = No Refills
Hemorrhoidal Cream/Ointment	Preparation H	30g Tube	Insert 1 Applicatorful Rectally TID PRN	Acute Use = No Refills
Hemorrhoidal Supp with Hydrocortisone	Anusol-HC Anucort	25mg HC per Suppository	1 Supp.rectally AM & HS 2-6 Days	Acute Use = No Refills
Hemorrhoidal Suppositories	Anusol	12 per Box	Insert 1 Rectally TID PRN	Acute Use = No Refills
Heparin	Heparin	5000u/ml,1ml Vial	Adjust by PTT Daily	
Heparin , low molecular weight (Dalteparin, Enoxaparin, Tinzaparin)	Fragmin , Lovenox, Innohep	varies with product	varies with diagnosis	Restricted to specialist order -attach consult copy to rx
Hepatitis A Vaccine	Havrix Vaqta	1440 El.u. 1ml 50 U	1 ml IM (Repeat in 6-12 Months)	For Chronic HCV Only
Hepatitis A/B Vaccine	Twinrix	1 ml Vials	1 ml @ 0, 1, 6 Mo	Per Hep C Guidelines
Hepatitis B Immune	Hep-B Gammagee H-	Vials,0.5ml preloaded Syringes	3-5ml (See Dosing Recommendations)	
Hexachlorophene	Phisohex	3% Suspension 150ml	5ml Lathered with H20,Scrub X 3 Min. Rinse Well	Use on Unbroken Non-abraded Skin Only
Homatropine Ophthalmic	Isopto-homatropine	2% Solution, 5% Solution	1-2 gtts BID to Q3-4h	
Hydrochlorothiazide	Oretic Hydrodiuril	25, 50mg Tablet	12.5-100mg Q am or Divided into 2 Daily Doses	
Hydrochlorothiazide oral	Oretic, Hydrodiuril	25mg Tablet #10	12.5-100mg Q am or Divided into 2 Daily Doses	
Hydrocortisone	Cortaid, Hytone	0.5% Cream 30g Tube, 1% Cream 30g Tube 1% lotion	Lightly Apply Small Amount to Affected Area TID for Simple Rash Apply Thin Film 1-4 Times QD	Acute Use = No Refills May use on face or scalp
Hydrocortisone Sod. Succinate	Solu-Cortef	100mg/2ml for Injection 250mg/2ml for Injection	100-500mg Q2-10H IM or IV over 30 Sec.	
Hydroxyzine HCl Inj	Vistaril	50mg/ml, 1ml Vial	25-100mg IM q4-6h	
Ibuprofen	Advil, Motrin, Rufen	400, 600, 800mg Tablet	Mild-moderate Pain:400mg Q4 to 6H PRN ,RA:400-800 mg 3-4 X Daily MAX 3200mg/day	
Ibuprofen oral	Advil, Motrin	200mg Tablet #24	Mild-moderate Pain:400mg Q4 to 6H PRN	
Immune Globulin	Gamastan, Gamma Globulin	10ml Vial, Hep B-4ml Hep A-1.4ml	Post Exposure: Deep IM, 10ml MAX per IM Site Measles-15ml	
Indinavir	Crixivan	200mg, 400mg Capsules	800mg Q 8h or 800mg +100mg or 200mg ritonavir BID	Drink at Least 1.5L of Liquid Daily
Indomethacin	Indocin	25, 50mg Capsule	25-50mg Po TID with Food	Caution If Used for More than One Month. SR Requires NF
Influenza Virus Vaccine, Trivalent	Fluogen, Flu Vaccine	100mcg/ml,5ml MDV	0.5ml IM	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Insulin Combination N and R	Humulin 70/30 Novolin 70/30	70%isophane & 30% Insulin	Titrate by Glucose Levels	
Insulin Glargine	Lantus	100units/ml 10ml vial	Titrate by glucose levels	SC administration only- Do not mix with other insulins
Insulin L Human	Humulin L, Novolin L	100units/ml,10ml Vial	Titrate by Glucose Levels	
Insulin N Human	Humulin N, Novolin N	100units/ml, 10ml Vial	Titrate by Glucose Levels	
Insulin R Human	Humulin R, Novolin R	100units/ml, 10ml Vial	Titrate by Glucose Levels	
Ipratropium	Atrovent	14g Oral Inhaler	2 puffs QID PRN	COPD Only
Ipratropium Nasal spray	Atrovent	0.03% , 0.06% spray pump	2 sprays 2 to 4 times a day	
Isometheptane, Dichloralphenazone, Acetaminophen	Midrin	65/100/325mg Capsule	2 at Onset, 1 Qh to MAX.of 5/12 Hr	MAX 10 Caps per Wk, 5 Refills in 6 Mo
Isoniazid	INH	300mg Tablet	900 mg Twice Weekly X 273 Days DOT Therapy Only (#234 tabs) - for relaese rx must be dosed daily	Unit Dose Watch Swallow
Isopropyl Alcohol Solution and Pads	Isopropyl Alcohol	Box		
Isosorbide Dinitrate	Isordil,Sorbitrate	5, 10, 20mg Tablet 40mg SR Tablet	2.5-20mg 3-4 x QD 20-40mg SR Q6-12h	Mononitrate is NF
Isotonic Nasal Saline	Ocean, Salinex	60ml Bottle	1 Spray in Each Nostril Q 4-6h	Acute use = No Refills
Ketoconozole	Nizoral	200mg Tablet	200-400mg QD.may Require to 6 Months	Baseline LFT's & F/U. Not for onchcomycosis
Ketorolac Injection	Toradol	15,30,60mg Inj	30-60mg IM Stat,15-30mg IM Q6h	No More than 120mg per Day, for 5 Days per Month
Lactulose	Chronulac, Cephulac	10g per 15ml	Constipation: 15-30ml(MAX 60ml)daily Higher Doses for Hepatic Encephalopathy	
Lamivudine (3TC)	Epivir	150 , 300mg Tablet	150 mg BID or 300mg qd	
Lamivudine (3TC), Zidovudine (AZT)	Combivir	150mg/300mg	1 BID	
Lamotrigine	Lamictal	25, 100, 150, 200mg Tablet	MAX 250mg/day	Restricted to psych at ASPC-PHX per mental health procedural instruction #13
Latanoprost Opthalmic	Xalantan	0.005% 2.5 ML	1drop affected eye qd	Restricted to specialist order- attach consult copy to rx
Leuprolide Depot	Lupron Depot	3.75, 7.5, 11.25, 22.5, 30mg Single use kit	3.75-7.5mg monthly	Restricted to specialist order- attach consult copy to rx
Levofloxacin	Levaquin	250, 500, 750mg Tablet	CAP 500mg q 24h	Restricted to post hospital continuity of care

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Levothyroxine	Synthroid, Levothroid	various strengths	0.1mg to 0.2mg QD:rarely to 0.3mg QD	
Lice Treatment Shampoo	A200, Pyrinyl Plus,RID Shampoo	2, 4 oz	Pediculosis Apply to Wet Hair for 10 Min-rinse Well Second Tx in 7-10 Days.	
Lidocaine Injection IM	Xylocaine	100mg/ml 5mlampule	300mg IM,may Repeat X 1 in 60- 90 Minutes	
Lidocaine Injection, IV	Xylocaine	20mg/ml 5 ml Syringe	IV Bolus 50-100mg Over1-2 Min	
Lidocaine Injection, Local	Xylocaine	1% or 2%, 30ml MDV	MAX 300mg Single Dose	
Lidocaine Ointment	Xylocaine	5% Ointment 35g Tube	Lightly Apply Thin Film PRN	
Lidocaine Viscous	Xylocaine Viscous	2%,100ml Bottle	15ml Swished and Spit out , or Gargled and Swallowed (Pharynx)	Not More than 8 Doses/24hrs, to Avoid Systemic Effect
Lidocaine with Epinephrine Injection, Local	Xylocaine	1% or 2% ,30ml MDV	MAX 500mg Single Dose	Avoid Use in Fingers and Toes
Lithium Carbonate	Lithonate	300mg Capsules	900-1800mg Daily in 1-4 Doses	Serum Li+ Levels must Be Monitored - UDWS
Lithium Citrate	Cibalith-S	Syrup, 500ml		Serum Li+ Levels must Be Monitored - UDWS
Loperamide	Imodium	2 mg Caps/tabs	2mg BID-TID	
Lopinavir/Ritonavir	Kaletra	133.3mg/33.3mg Capsule	3 BID	
Loratadine	Claritin	10mg Tablet	10mg QD	
Lorazepam	Ativan	0.5, 1, 2mg Tablet	per alcohol withdrawal protocol	Restricted to alcohol withdrawal protocol
Losartan	Cozaar	25, 50, 100mg Tablet	25-100mg/day as a single dose or divided in 2 doses	Restricted to use after failure or intolerance of an ACEI
Lovastatin	Mevacor	10, 20, 40mg Tabs	10-80mg QD	2nd line after niacin or gemfibrozil - 1st line for diabetics and post MI
Magnesium Citrate Solution	Citroma	240ml	Drink Entire Contents of Bottle	Unit doses (glass bottle) watch swallow
Magnesium Hydroxide Suspension	MOM, Milk of Magnesia	400mg/5ml 30ml U/D	Laxative:30ml-60ml/day with liquid	Acute Use = No Refills
Measles/Mumps/Rubella	MMR	1 Vial		
Measles/Rubella	MR	1 Vial		
Meclizine	Antivert	25mg Tablet	25-200mg/day in Divided Doses	
Meclofenamate	Meclomen	50, 100mg Capsule	1 TID or QID MAX, with Food	Not Recommended for Initial Tx of RA
Medroxyprogesterone	Provera	10mg Tablet	5-10mg QD X 5-10d,start on 16th or 21st Day	Female Use Only
Meperidine	Demerol	50mg Tablet 100mg Tablet	50-150mg Po Q 3-4H	Schedule II Drug, Rx 7 Days MAX (Watch Swallow Only)

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Meperidine Injection	Demerol	25mg/2ml 50mg/2ml 75mg/2ml 100mg/2ml Syringe	50-150mg IM Q3-4h	Schedule II Drug, Rx 7 days MAX
Mesalamine oral	Ascol, Pentasa	250mg CR Capsule & 400mg DR Tablet	Tablets -800mg tid, Capsules -1000mg qid	Restricted to specialist order- attach consult copy to rx
Mesalt	Mesalt	Topical	Topical	IPC Units Only
Metformin	Glucophage	500,850mgTabs	1000mg to 2550mg per Day in Divided Doses	
Methadone	Methadone	5 mg, 10 mg	Individual basis, Preferred long acting agent for chronic long term pain relief.	NF Required
Methenamine Mandelate	Mandelamine	1 Gram	1g BID-QID	
Methimazole	Tapazole	5mg Tablet	5-30mg QD in 3 Divided Doses, MAX 40 mg QD	
Methocarbamol	Robaxin	500mg, 750mg	500mg QID 750mg qid	Limited to 14 Days Tx per 12 Weeks
Methotrexate oral		2.5mg Tablet	7.5 -30mg per week	Restricted to specialist order -attach consult copy to rx
Methyl Salicylate/Menthol Analgesic Balm	Ben Gay	30g Tube Ointment/cream	Apply 2-3 Times QD	Acute Use = No Refills
Methylprednisolone Dose Pack	Medrol Dose Pack (Similar to)	4mg	Follow pkg Instructions	
Methylprednisolone-Depo	Depo-Medrol	40mg, 80mg/ml, 1ml Vial	40-80mg Qweek IM,intra-articular, Lesional,soft Tissue	
Metoclopramide	Reglan	10mg Tablet	5-15mg 30 Min. AC & HS	
Metoprolol	Lopressor	50, 100mg Tablet	50-450mg/day in single or divided doses	
Metronidazole	Flagyl	250mg, 500mg Tablet	250mg TID X7 Days, 500mg or 2g gs 1x dose	
Mineral Oil	Mineral Oil	1	1-2 Tablespoons HS	Do Not Give Docusate with this
Minoxidil	Loniten	2.5mg, 10mg Tablet	5mg to 40mg Daily in 1 or 2 Doses	
Morphine	Duramorph	15mg/2ml Syringe	5-20mg SQ or IM Q4H PRN	Schedule II Drug, Rx 7 Days MAX
Morphine Sulfate	Morphine	10mg/2ml Syringe	5-20mg SQ or IM Q4H PRN	Schedule II Drug, Rx 7 Days MAX
Mycophenolate oral	Cellcept	250mg Capsule, 500mg Tablet	1- 1.5gm BID	Restricted to specialist order -attach consult copy to rx
Nalbuphine	Nubain	10 mg/ml	10 mg IM/IV	May Precipitate Narctotic Withdrawl
Naloxone	Narcan	0.4mg/ml Ampule	0.4-2mg IV; May Repeat at 2-3 Min Intervals	Narcotic Overdose
Naphazoline/Antihistamine	Vasocon A, Naphcon A	0.05%/0.5% Ophthalmic Solution, 15ml	1-2 gtts Q3-4H or less PRN	
Naproxen	Naprosyn	250mg, 500mg	250-500mg BID	
Nelfinavir	Viracept	250 , 625mg Tablets	750 mg TID or 1250 mg BID	Take with Food

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Neomycin, Polymixin, Hydrocortisone Otic Suspension	Cortisporin	10 ml Suspension	4 gtts 3-4 Times QD Limited to 7-10 Days	
Nevirapine	Viramune	200mg Tablet	200mg QD x 14days then 200mg BID	
Niacin	Vitamin B3	100mg, 500mg Tablets 500mg SRCaplet	Antilipemic 0.5-1g TID MAX 6g/day (SR MAX 2g/day)	
Nifedipine	Procardia, Adalat	10 mg, 20 mg Capsule	10-60mg TID	For Tx of Angina Only
Nitrofurantoin- Macro	Macrodantin	100mg Capsule	50-100mg QID	
Nitroglycerin Ointment	Nitrol, Nitro-BID	2%,60g Tube	1-2" to 4-5" Q 8H Spread over Uniform Area QD	May keep in clinic stock if desired
Nitroglycerin SL	Nitrostat	0.4mg Tablet #25	1 SL may repeat q 5 min x 2	
Nitroglycerin SL	Nitrostat Ntg	0.3mg 0.4mg 0.6mg, SL Tablet, 25's	0.15-0.6mg SL, may repeat Q 5 Min. X2	
Nitroglycerin-SR	Nitrobid (DC by Mfg)	2.5mg 6.5mg 9mg, SR Capsules	2.5 - 9mg BID-TID	Transdermal patches NF
Norethindrone Ethinyl Estradiol 1 + 35	Norinyl, Orthonovum,Genora, Nelova	1mg/35 mcg Tablet,28's	1 QD Starting 5th Day of Cycle	1st line for menorrhagia Need In-house OB Consult by PV
Nystatin Cream	Mycostatin, Nilstat	100,000u/g,15g Tube	Lightly Applied To Affected Area Several Times QD	
Nystatin Oral Suspension	Mycostatin, Nilstat	100,000u/ml,60ml	4-6ml Swished Orally as Long As Possible QID,swallowed, To 14 Days	
Omeprazole	Prilosec	20mg Capsule	20- 40mg/ day	Restricted to use after failure of famotidine 40mg/day x 6 weeks or H Pylori
Oxybutynin	Ditropan	5mg, 10mg Tablets	5-10mg TID-QID	
Pancrelipase	Pancrease, Cotazyme	Capsules-EC, SR.	1-3 AC or with Meals, Adjust to Diet, Condition and Response	
Paroxetine	Paxil	40mg	20-50 mg QD	3rd line antidepressant -No NF Required Following Adequate Trial of Fluoxetine & Citalopram (6 weeks)
Peg Electrolyte for Solution	Golytely, Colyte	4800ml Solution	240ml Q10 Min. Until 4800 ml Is Consumed	
Peginterferon alpha 2a	Pegasys	180mcg vial or syringe for injection	180mcg/day SQ weekly (dose may require modification per protocol)	For HCV treatment Requires approval of Hepatitis C committee
Pencillin G, Benzathine	Bicillin-LA	0.6mu/1ml,1.2mu/2ml,2.4mu /4ml Syringe	0.6-2.4mu IM Q Week	Refrigerate
Pencillin G, Procaine	Wycillin	0.6mu/1ml, 2.4mu/4ml Syringe	0.6mu/1ml QD-BID Deep IM X7-10d,4.8mu, divided Sites with 1g Probenecid X1 Deep IM	Refrigerate
Pencillin VK	V-Cillin K, Pen VK, VEETIDs	250, 500mg Tablet	250-500mg Q 6-8H	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Penicillin V K oral	V-Cillin K, Pen VK, VEETIDs	500mg Tablet #28	500mg Q 6-8H	
Pentoxifylline	Trental	400mg Tablet	400mg TID with Meals	
Permethrin	Elimite, Actictin	5% cream	Apply for 8-14 hr	1 Tube contains 2 applications
Perphenazine	Trilafon	2, 4, 8, 16mg Tablet	12-64mg/day in 2 to 4 divided doses	
Phenazopyridine	Pyridium	100mg, 200mg Tablet	100-200mg TID Pc	Do Not Chew, May Stain
Phenylephrine	Neo-Synephrine	10mg/ml 1 ml Ampule	2-5mg IM Q 1-2H For Mild to Moderate Hypotension	
Phenytoin Extended	Dilantin	100mg Capsule	200-600mg Daily Single Dose	
Phenytoin Injection	Dilantin	50mg/ml, 5ml Vial	Status Epilepticus:150-250mg IV @ 10-15mg/min.	Not to Be Mixed in IV Fluids
Physostigmine	Antilirium, Eserine	1mg/ml Amp	1mg IM or 1mg/min.slow IV,q 20min	
Phytonadione	Aqua-Mephyton, Vitamin K	10mg/ml 1ml Amp	2.5-10mg IM to 10-50mg Slow IV	
Pneumococcal Vaccine	Pneumovax, Pnu-immune	23 Polysaccharide Isolates	0.5 ml SQ or IM Deltoid, Thigh	(Not IV,avoid Intradermal)
Podophyllin Resin	Podoben	25%/5ml Benzoin,	Cover Area by Using 1 Drop, Dried, at a Time.Wash off in 1-4H	Keep in Health Unit
Potassium Acid Phosphate	K-phos	500mg Tablet	2 Dissolved in 240ml Water,QID with Meals & HS	Use with Protocol Or Consult Recommendation
Potassium Chloride for Solution	Klorvess, K-lor	20 meq/ Packet Oral	40-80 meq/day In Divided Doses, In Large Amount Of Water/juice	
Potassium Chloride SR	K-tab, Micro-k 10, Ten K	10 meq Tablet	20-80 meq QD, Divided Doses	
Povidone-Iodine	Betadine	Various Forms Including Douche		
Prazosin	Minipress	1mg, 2mg, 5mg Capsule	6-15mg/day, in Divided Doses	1st line BPH
Prednisolone Ophthalmic	Pred Mild, Pred Forte, Inflamase Forte	0.125% 5ml, 1% 5ml	1-2 gtts Q 3-12H to 1-2 gtts QH during Day, Q 2H Night	Suspension: Shake Well
Prednisone	Deltasone	5mg, 20mg Tablet	Initial: 5-60mg In Divided Doses. Adjust to Condition And Response	
Primidone	Mysoline	50mg, 250mg Tablet	Slowly titrate upward in 3 to 7 day increments. MAX 2G/day	
Probenecid	Benemid	500mg Tablet	1g 1/2hr Before PCN G	
Procainamide	Pronestyl, Procan	250mg, 375, 500mg Capsule	0.5-1g Q4-6 H	

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Procainamide Injection	Pronestyl	500mg/ml 2ml Vial	IM: 100mg-1g Q 4-8H. IV:50-100mg @25-50mg/min.q5min. 500mg	IV to Be Diluted in D5W
Procainamide SR	Procan SR	500mg, 750mg, 1000g Tablet	MAX 1g Q 6H	
Promethazine	Phenergan	25mg Tablet	12.5-50mg to TID,25-50mg HS	
Promethazine Injection	Phenergan	25mg/ml Ampule	12.5-50mg IM Q 4H: MAX.100mg/Q 24H	
Promethazine Suppository	Phenergan	25mg 50mg	12.5-50mg to TID, 25-50mg HS Rectally	
Propafenone	Rhythmol	150, 225, 300mg Tablet	150 -300mg q8h	Restricted to specialist order -attach consult copy to rx
Propoxyphene N / Acetaminophen	Darvocet N	100mg/ 650mg Tablet #6	1 Q 4H If Needed, MAX 6/day	Watch Swallow Only
Propoxyphene-N, Acetaminophen	Darvocet-N	100mg/650 mg Tablet	1 Q 4H If Needed, MAX 6/day	Schedule IV Drug Rx 7 Days MAX
Propranolol	Inderal	10mg, 20mg, 40mg, 60mg, 80mg Tablet	40-480mg QD Divided Doses, PC & HS	
Propylthiouracil	PTU	50mg Tablet	300-450mg QD or More, Then Reduced To 100-150mg QD Divided Doses	
Pseudoephedrine/Triprolidine	Actifed	Tablet	1 Tab 3-4x Daily	Limited to 14 Days Tx per 12 Weeks
Psyllium Mucilloid	Metamucil Konsyl	Powder, 200g Bottle	1 Tablespoon (11g) in Water/juice 1-3 X QD	Acute Use = No Refills -Exception mental health rx
Psyllium Mucilloid (Sugar Free)		283g	1 Teaspoonful (3 or 4 g)	Acute Use = No Refills -Exception mental health rx
Pyrethins, Piperonyl Butoxide	Rid A-200 Pyrinyl	60ml Liquid Various Strength	Apply to Affected Area X10 Min. Only, Wash Well	Repeat in 7 Days
Pyridoxine	Vitamin B6	50mg Tablet	100-600mg QD Short Term, then 10-50mg QD	
Ribavirin	Copegus, Rebetol	200mg Capsule	Weight based	MUST BE WATCH SWALLOW -For HCV treatment Requires approval of Hepatitis C committee
Rifampin	Rifadin, Rimactane	300mg Capsule	TB:600mg QD with Other TB Agent, MRSA: 300mg with trimeth/sulfa x 10 days	TB - unit dose watch swallow MRSA - DO NOT USE ALONE
Risperidone	Risperdal	0.5, 1, 2, 3, 4 mg Tablet	1-6mg QD	First line (or typical) Must Follow Antipsychotic Algorithm. NF required for doses greater than 6 mg QD
Ritonavir	Norvir	100 mg Capsules	only recommended as booster to other protease inhibitors	Take with Meals

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Rosiglitazone	Avandia	2, 4, 8mg Tablet	4-8mg/day as a single dose or divided in 2 doses	Restricted to use after failure of at least 2 of the following agents in combination: Metformin, Glyburide, Insulin at optimal doses - trial must be for at least 12 weeks with failure to achieve HbA1C of 7 or less
Salicylic Acid	Salacid, Hydrosal	25% Ointment, 60g	Apply Ointment over Cleansed Area,leave on X 48H, Wash. May Repeat MAX 5 Times in 14 Days	
Salicylic Acid Lactic Acid	Duofilm, Salactic	Colloidion 15ml	Apply to Cleansed Area, Dry, 1-2x QD for 1week	Keep in Health Unit
Salsalate	Disalcid	750mg Tablet	1 TID to 2 Q 12H	
Saquinavir	Invirase,Fortavase	200 mg Caps	1000mg + 100mg ritonavir BID or 400mg + 400mg ritonavir BID	Take with Meal
Selenium sulfide lotion	Selsun	2.5%	Apply to affected area -lather -leave 10 minutes and rinse daily x 7days	Restricted to tinea versicolor with no refills
Sevelamer	Renagel	400, 800mg Tablet	800- 1600mg tid with meals	Restricted to specialist order-attach consult copy to rx
Shampoo, Baby	Baby Shampoo	1		Restricted for Eyelash Infections
Silver Nitrate	Silver Nitrate		Applicators Applied to Hemmorrage	Properly Dispose of Poison
Silver Sulfadiazine	Silvadene	1% Cream	1/16" over Cleansed Burn 1-2 X QD with Sterile Applicator Glove	Properly Dispose of Poison
Simethicone	Mylicon	80mg Chewable Tablet	1 QID PC & HS, Chewed Well, Followed by Water	
Soap, Antibacterial		Bar		Acute Use = No Refills
Sodium Bicarbonate Inj	Sodium Bicarbonate	50 meq/50ml		
Sodium Chloride 0.9% Solution	Normal Saline		MedicalSupplies	
Sodium Phosphates Enema Solution	Fleet Enema	220mg Phosphates/ml, 133ml Bottle	1 Rectally	
Spironolactone	Aldactone	25mg Tablet	25-200mg QD Single Dose or Divided	
Stavudine (D4T)	Zerit	20,30,40mg Capsule	20-40 mg BID	
Sterile Water, USP	Water		MedicalSupplies	
Sulcralfate	Carafate	1g Tablet	1g 1hr Pc & HS X4-8 Wks for Ulcers	No Antacids 1/2hr Before or after Sucralfate
Sulfacetamide 10% Ophthalmic	Sulamyd, Bleph 10, Sulfair 10	Ointment 3.5g Tube Solution 15ml	2cm under Lower Eyelid 4 X QD & HS 1-2 gtts Q 2-3H	
Sulfacetamide Phenylephrine Ophthalmic	Vasosulf	Solution 15%/0.125%,5ml	1-2 gtts 3-6 X QD	Not available at this time

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Sulfasalazine	Azulfidine	500mg Tablet	2 QID PC with Water, MAX 4g QD	
Sunscreen (@ Least SPF 30)	Presun, Sundown	SPF 30	Apply MAX Q 1-2H During Exposure	Acute Use = No Refills unless ordered for documented photo-sensitivity reaction - then 1 bottle/month MAX (March - October)
Tacrolimus oral	Prograf	0.5, 1, 5mg Capsule	Titrated	Restricted to specialist order -attach consult copy to rx
Tamoxifen	Nolvadex	10mg	10mg BID-TID	
Tears, Artificial	Tearisol, Liquifilm, Hypotears	15ml Ophthalmic Drops	1-2 gtts 3-4 Times QD	Acute Use = No Refills
Tenofovir	Viread	300mg Tablet	300mg qd	
Terazosin	Hytrin	1mg,2mg,5mg 10 mg Tablet	1-10 mg QHS	Second Line BPH -See Algorithm
Terbutaline	Brethine, Bricanyl	2.5, 5mg Tablet	2.5-5mg to TID -Q6h, MAX 15mg/day	
Terbutaline Injection	Brethine, Bricanyl Sol	1mg/ml Sol		Cessation of premature labor
Tetanus Immune Globulin	Hyper-Tet	250 Unit Vial or Disp. syringe		Refridgerate
Tetracaine Ophthalmic	Pontocaine	Solution 0.5%, 2ml Sterile Unit	1-2 Drops	
Tetracycline	Sumycin Achromycin	250mg, 500mg Capsules	250-500mg QID	On an Empty Stomach - No Antacids
Tetrahydrozoline	Murine-Plus, Visine	0.05% Eye Solution, 15ml	1-2 gtts MAX 4x QD, 3-4 Days Only	
Theophylline SR	Theodur, Theolair SR	200mg, 300mg Tablet	MAX 900mg QD in 2-3 Doses	
Thiamine Inj.	Thiamine	100mg/ml 2ml MD Vial	100mg IV daily for acute alcohol withdrawal if NPO	Run 100mg in 1 liter IV
Thiamine oral	Vitamin B1	50mg Tablet	1.5-100mg/day	
Thiothixene	Navane	1, 2, 5, 10, 20 Capsule	6-30mg/day to 60mg/day Maximum	
Thiothixene for Injection	Navane	2mg/ml 2 ml Vial 5mg/ml 2ml Vial	16-20mg QD IM in 2-4 Doses	
Timolol Ophthalmic	Timoptic	0.25%, 0.5% Solution	1 gtt QD or BID	
Tipranavir	Aptivus	250mg	500mg with 200mg ritonavir twice daily	
Tolnaftate Cream	Tinactin	1% Cream, 15g Tube	Small Amount Sparingly BID to 6 Weeks	OTC: 1 Tube per Month
Tolnaftate Powder	Tinactin	1% Powder 45g	Small Amount Dusted , BID for MAX 6 Weeks	
Tolnaftate Solution	Tinactin	1% Solution 10ml	2-3 gtts Gently Rubbed In, BID for MAX 6 Weeks	
Tolterodine Extended Release	Detrol LA	2, 4mg Capsule	2-4mg/day	Restricted to use at Perryville
Topical Moisturizing Creams and lotions	Eucerin, Aquaphor, Lobana,Etc.	60g jar, 120ml bottle		No refills

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Triamcinolone	Kenalog, Aristocort	4mg Tablet	4-48mg/day in 1-4 Doses Adjust to Condition and Response	
Triamcinolone Cream	Kenalog, Aristocort	0.025%, 15g, 80g Tube 0.1%, 15g,80g Tube 0.5%, 15g Tube	Apply Thin Film Sparingly 2-4 x QD	
Triamcinolone Dental Paste	Kenalog in Orabase	0.1% Oral,5g Tube	0.5cm Pressed on Lesion 2-3xd & HS PRN X7D	
Triamcinolone Injection	Kenalog	40mg/ml 1ml Vial Suspension,40mg/ml, 5ml Mdvl Suspension	5-60mg IM at 6 Week Intervals	Shake Well
Triamcinolone Lotion	Kenalog, Aristocort	0.01%, 0.025%, 60ml Lotion	Apply Thin Film Sparingly 2-4 x QD	Shake Well
Triamcinolone Nasal Inhaler	Nasacort	55mcg/inhaler	1-2 Sprays per Nostril QD MAX 2 Sprays per Nostril BID or 1spray per Nostril QID	Nasal polyps only
Triamcinolone Ointment	Kenalog, Aristocort	0.025%, 0.1%,15g, 80g Tube	Apply Thin Film Sparingly 2-4 x QD	
Triamcinolone/Nystatin Cream	Mycolog	0.1%/100,000 U/g, 15g Tube	Apply Lightly Affected Area 2-4 x QD	
Triamcinolone/Nystatin Ointment	Mycolog, Tri-Statin	0.1%/100,000 U/g,15g Tube	Apply Lightly Affected Area 2-4 x QD	
Triamterene/HCTZ	Maxzide	75mg/50mg Tablet	1/2 to 1 Tab BID PC:	Check Serum K+periodically
Trifluoperazine	Stelazine	1mg, 2mg 5mg, 10mg Tablet	MAX 20mg/day	
Trifluoperazine Injection	Stelazine	2mg/ml 10ml Vial	1-2mg Q4-6h IM, not to Exceed 6mg/24H	
Trimethobenzamide Injection	Tigan	100mg/ml-2ml	IM: 200mg 3-4 x QD	Oral Not on Formulary
Trimethobenzamide Suppository	Tigan	200mg Suppository	Rectally: 200mg 3-4 x QD	Oral Not on Formulary
Trimethoprim/Sulfamethoxazole	Bactrim DS, Septra DS	160mg/800mg Tablet	1 BID with Water	
Triple Antibiotic Ointment	Mycitracin, Neosporin	1g Packets,15g Tube	Apply Lightly TID X 3-5 Days	Acute Use = No Refills
Triple Antibiotic Ophthalmic Ointment	Neosporin	3.5g Tube	½" under Lower Eyelid 2-3 x QD	
Triple Antibiotic Ophthalmic Solution	Neosporin	10ml	1-2 gtts 2-6 X QD	
Tuberculin, Purified Protein Derivative	Tubersol, Aplisol, Mantoux, PPD	5 Test 0.1ml ,units/0.1ml 5 ml Vial, 50 Tests	Intraderm with 26-27 Ga Needle	Refrigerate
Valproic Acid	Depakene	250mg Capsule	MAX 4g QD in 2-3 Doses with Meals, Food	
Venlafaxine XR	Effexor XR	37.5, 57,150mg XR Capsule	75- 225mg/day	3rd line antidepressant -No NF Required Following Adequate Trial of Fluoxetine & Citalopram (6 weeks)

ADC Formulary - Complete Listing

Generic	Brand	Strength/size	Dose	Restrictions
Verapamil	Isoptin, Calan	180 mg SR Tablet 240mg SR Tablet	240-480mg Per Day	SR Only
Vitamin B complex with C renal formula	Nephrocaps, Nephplex, Nephro-Vite	Capsule/Tablet	1 QD	Restricted to specialist order -attach consult copy to rx
Vitamins, Multiple	One a Day	Tablet	1 QD	Dialysis Patients
Vitamins, Prenatal	Materna-FA Multiple-FA	Tablet	1 QD	Pregnancy And/or HIV Patients Only
Warfarin	Coumadin	2, 2.5, 5, 7.5mg Tablet	10-15mg QD X 2-5 Days, Then 2-10mg QD	Dosage must Be Individualized
Witch Hazel Pads and Solution	Tucks	1	PRN after BM's	
Zalcitabine, DDC	Hivid	0.75mg	0.75mg Q8h	
Zidovudine(AZT)/Lamivudine(3TC)	Combivir	150mg/300mg Tablet	1 BID	
Zidovudine, AZT	Retrovir, AZT	300mg Tablet	300mg BID	
Ziprasidone Injection	Geodon	20mg pdr for inj. SD Vial	10-20mg/dose up to 40mg/day IM	Restricted 7days without an NF
Ziprasidone oral	Geodon	20, 40, 60, 80mg Capsule	20-80mg BID	3rd line- Must Follow Antipsychotic Algorithm- Restricted to use after failure of risperidone & typical trial (4 weeks at target dose)